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Stephanie N. Terrell  
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SELF-CARE PRACTICES FOR DANCE/MOVEMENT THERAPY STUDENT INTERNS: A  
MULTIFACETED TOOLBOX

Stephanie N. Terrell

Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

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Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA  
Chair, Creative Arts Therapies

Laura Downey, PhD, BC-DMT, LPC, GL-CMA  
Research Coordinator

Laura Allen, MA, BC-DMT, LCPC, GL-CMA  
Thesis Advisor

Shannon Suffoletto, MA, BC-DMT, LCPC, GL-CMA, MPAC  
Reader

## **Abstract**

The purpose of this project was to create tools for self-care practices that help second-year dance/movement therapy (DMT) students at Columbia College Chicago cope with possible risks encountered within clinical practice. The importance of developing effective self-care habits for practitioners in therapeutic professions is emphasized in literature, and it is encouraged that this self-care practice is developed during a student's graduate training experience. Literature in the areas of therapists' self-care practices, counselor development, burnout, compassion fatigue, countertransference, somatic countertransference, therapist distress, and vicarious traumatization are reviewed. A product development methodology was used, the Eight Stage-Gate Process for New Product Development, which involved the collection of external input through a survey gathering quantitative and qualitative data about respondents' own self-care practices. A total of 125 surveys were distributed online with a 49% response rate. Input was analyzed using statistical analysis of quantitative input and summative content analysis of qualitative input. The survey provided insight into the possible risks of being a therapist experienced by DMT student interns, how different types of self-care were prioritized, and what types of self-care were difficult to include in individual self-care practices. From this input, a booklet and website were created and made available to future students enrolling in Columbia College Chicago's program. The website provides information about therapist self-care, resources for student interns, and information about approaching self-care holistically. The booklet provides student interns with a guided process to forming a self-care practice, including assessments and recommendations for specific activities.

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“It’s not selfish to love yourself, take care of yourself, and to make your happiness a priority. It’s necessary.” – Mandy Hale

## **Chapter One: Introduction**

My path to becoming a dance/movement therapist was vulnerable, empowering, and demanding. I pursued my graduate education in dance/movement therapy (DMT) through Columbia College Chicago’s (CCC) traditional route. The program challenged me to find myself as an individual and future therapist, and I experienced incredible amounts of personal growth. However, I also found myself suffering under the weight of the obligations and responsibilities I was expected to fulfill. The program asked me to balance full-time coursework, clinical experiences, and thesis requirements. All these requirements, in addition to my personal life, was a lot to juggle. There were days that I questioned my decision to pursue this career and doubted my choices. There were days I could barely drag myself out of bed and my entire being vibrated with unrelenting anxiety.

Thankfully, these days did not represent the majority of my experience as a graduate student, but it was difficult not to become overwhelmed. What became essential for my survival in the program was self-care. I began to recognize the importance of self-care and wanted to establish it as a priority in my life. It was not a new concept to me as I was constantly told by supervisors, professors, my personal therapist, and peers that self-care was crucial. It was engrained into my brain, but what did self-care mean? Was it enough to call my mother once per week and talk? Did I need to start jogging one mile a day? *What did it mean to do self-care?* I knew I needed it, but I was lost in the ambiguous cloud of trying to define my own self-care practice.

There is no single definition of self-care. Depending on what field you work in and what authors you read, self-care has several different definitions. Self-care is part of a person's lifestyle; it influences well-being and how an individual perceives and responds to their environment. Within the literature for therapist self-care, one comprehensive definition is, "The processes of self-awareness and self-regulation and the balancing of connections among self (involving the psychological, physical and spiritual, as well as the professional), others (including personal and professional relationships), and the larger community (encompassing civic and professional involvement)" (Baker, 2003, p. 13-14).

Students wanting to work in the helping professions, such as therapy, social work, medicine, nursing, and counseling may face possible risks during their training. The potential risks can include burnout, compassion fatigue, unresolved countertransference, therapist distress, unresolved somatic countertransference, and vicarious traumatization. When experiencing these risks, students may be deterred from pursuing their career and suffer from symptoms and illnesses affecting them physically, psychologically, and emotionally (Diaconescu, 2015; Forester, 2007). Coping with professional challenges can be even more overwhelming when also coping with personal hardships, such as financial pressures, school-related stressors, and/or disruption of support systems (Cushway, 1997). Self-care can help these students to cope with both personal and professional vulnerabilities rather than be overwhelmed. Learning to cope with both personal and professional stressors through the use of self-care is essential for emerging dance/movement therapists, and ideally these skills would start to develop while in a graduate training program (Baker, 2003; Turner et al., 2005; Weiss, 2004).

The motivation for this project arose from my own difficulties in creating and maintaining a consistent self-care practice while a student in CCC's Dance/Movement Therapy

& Counseling (DMTC) program. Two assumptions formed from my personal experiences and inspired the development of this project. The first assumption was that most DMT student interns have experienced at least one of the possible risks of being a therapist. The second assumption was that developing a self-care practice during graduate school is highly valued. Self-care has been a topic advocated by faculty of the program and students are actively encouraged to use self-care regularly. The process of creating a self-care practice is highly individualized, however, and requires dedicated research and experimentation to find what works for each person. Although there is an abundance of literature about self-care practices and its importance, this abundance can be overwhelming for student interns. The broadness of the literature does not lend itself to providing concrete options for interns, but expects interns to relinquish their own limited time and energy to researching and creating a self-care practice.

My experience in trying to create my own self-care practice was overwhelming and discouraging. I limited my personal exploration into self-care and did not consider what I needed to feel nourished. I struggled to create my own self-care practice, because I forced other peoples' practices to be my own without knowing what I truly needed from self-care. My practice was comprised of various self-care activities that worked for other people, and I assumed that if it did not work for me then I was wrong. Over time, I began to recognize this pattern and stopped seeking the answers from external sources. I needed to start by listening to myself first and know my needs, and then I could use external resources to provide me with options for self-care activities. These experiences motivated me to create self-care tools to act as a reference for other student interns in the creation of their own unique self-care practice.

I chose to create multifaceted self-care tools that fully engage the body/mind/spirit connection, as it aligned with the values and beliefs of my career as a dance/movement therapist.



The body/mind/spirit connection used in DMT was a guiding tenet for this project, and inspired my holistic approach to self-care emphasized in the products. As therapists, we are asked to be aware of all parts of Self through this integrated connection as we work with our clients. I believe a similar approach can be used when it comes to therapist self-care, because all these parts are interconnected and equally deserving of care. The guiding questions for my process were: What self-care activities are most effective for DMT student interns at CCC? What would a multifaceted self-care tool look like for DMT student interns? What body-based self-care activities are most effective for DMT students at CCC?

Current literature on self-care practices offers ideas for activities for how therapists can care for themselves personally and professionally, but this project aimed to create a more concise, focused tool for second-year DMTC students. The creation of these products used external input from alumni and current students of the DMTC program, in addition to a review of current self-care literature. The tools that I created for this project were a booklet and website, which disseminates information and provides students with guidance when creating a self-care practice.

Rather than writing about abstract ideas on how to approach self-care, concrete products were created for students to use and inform their own exploration of developing a self-care practice. This thesis will not provide all DMT student interns with all the answers to questions about self-care, but it is a step in the right direction. What was found in this thesis will not be helpful to every student, and it is unreasonable to expect this result. However, this contribution to the field of dance/movement therapy literature expands the conversation about therapist self-care and its importance, and provides concrete resources to be sampled by interested individuals. The

next section will be an overview of current literature regarding therapist development, possible risks of being a therapist, and therapist self-care.

## **Chapter Two: Literature Review**

The experience of being an intern is common, if not required, for those seeking a career as a therapist within the field of mental health. It is an opportunity for graduate students to step into a professional context and apply the knowledge and skills learned in the classroom, but the intern role is limited. An intern is not full-time staff and will not have all the responsibilities of fully employed staff members; however, they are observing and exploring the tasks and responsibilities of a full-time therapist. Despite this limited role, interns are trying on the new identity of therapist and made vulnerable to the possible risks of being a therapist.

These risks may vary depending on the internship site, but regardless of population, interns are often not equipped with the self-care (see Appendix A) skills to protect themselves against the possible risks. Burnout, compassion fatigue, unresolved countertransference, unresolved somatic countertransference, therapist distress, and vicarious traumatization are some of the risks that have been found to affect interns at a higher rate than experienced therapists (Skovholt & Rønnestad, 2003; Turner et al., 2005). However, interns can prevent and treat symptoms that may arise through the use of self-care. This literature review examines the development of therapist interns, potential risks of being a therapist, the experience of being a DMT intern, and self-care recommendations present in literature.

### **Professional Development as Therapists**

The formation of a professional identity (see Appendix A) as a therapist is important, and the clinical internship experience is one method to create effective, ethical professionals in the mental health fields. Skovholt and Trotter-Mathison (2014) define professional identity as a process that, “involves the merging of one’s values, theoretical beliefs, and skills. It involves shedding values, beliefs, and skills that no longer fit and adding others” (p. 40). For students, an

internship experience is a first step of developing professional identity. Students try on the role of clinician; applying what was learned in the classroom to real clients and discovering what theories align with their personal approach to therapy. This is also the opportunity for students to try various approaches to therapy, and discard approaches that are not compatible.

According to Rønnestad and Skovholt (2003), there are five phases that represent the development of a therapist: lay helper, beginning student, advanced student, experienced professional, and senior professional. These phases of development were uncovered after conducting semi-structured interviews with 100 American therapists with varying levels of experience. For the purpose of this thesis and its focus on the experience of a graduate student intern, the first three phases of Rønnestad and Skovholt's (2003) model will be further examined.

**The lay helper.** Throughout a person's life, there will be moments in time where they will help another person in their different roles of friend, coworker, parent, peer, etc. (Rønnestad & Skovholt, 2003). During these helping experiences, people will rely on their personal experiences or perceptions of common sense with similar dilemmas, give direct advice, and provide emotional support. In this lay helper phase, main concerns include over-involvement, over-identification, projection, difficulty self-regulating emotional engagement and reactions, and a lack of clear boundaries between the helper and the person being helped. During this phase, the lay helper may feel as if these experiences are authentic, but lack the skill sets to cope with the repercussions and the ability to maintain objectivity. Some lay helpers will become interested in pursuing a career as a therapist and transition into a new phase as they enter a graduate training program.

**The beginning student phase.** Graduate students will typically enter the beginning student phase while starting to learn theory and application in the classroom; this phase extends

into the beginning of clinical experiences of practicums and internships (Rønnestad & Skovholt, 2003). During this phase, the student will begin accumulating basic skills and gain the ability to distinguish between what is appropriate and inappropriate helping. Students usually have a mixture of emotions about their first clinical experiences including excitement, anxiety, guilt, distress, overwhelm, and uncertainty. During this phase, students tend to use external sources to measure their development and success, such as feedback and criticism from supervisors, peers, and clients.

These training experiences may be the first clinical experience for some students, or the student may be starting a second career and experiencing a new clinical role. For students in their first clinical experience, this time is often characterized by feeling anxious and threatened, while also experiencing feelings of excitement and competence (Rønnestad & Skovholt, 2003). Some specific challenges students face during this phase includes performance anxiety, ambiguous professional standards, developing appropriate boundaries with clients, an undeveloped professional identity, application of theories and concepts to actual clinical work, unrealistic expectations, and the need for positive mentors (Skovholt & Rønnestad, 2003). Over time, student interns will transition into the advanced student phase, which parallels a shift in expectations for interns' responsibilities on-site. Student interns will begin taking a more active role as a clinician with supervisors or other full-time staff taking a more supportive role. What was found to be helpful in the beginner student phase was learning and applying straightforward therapy approaches and an "attitude of openness to new learning" (Rønnestad & Skovholt, 2003, p. 13).

**The advanced student phase.** Student interns will experience the advanced student phase for the majority of their practicum and internship experiences; the main goal is for interns

to begin functioning at a basic professional level (Rønnestad & Skovholt, 2003). Interns continue to rely on external validation and confirmation from supervisors and peers (Rønnestad & Skovholt, 2003). The challenges of the beginning student phase are still present, along with feelings of insecurity and vulnerability, and often manifests as professional conservative and cautious behaviors when working with clients (Rønnestad & Skovholt, 2003). Unrealistic expectations during the advanced student phase create more stress for the interns. Student interns will balance a variety of stresses, such as the stress of conducting therapy with clients, feelings of competition among peers, poor supervision, a large workload from their numerous roles in their lives, a disruption of social support, financial pressure, and self-doubt (Cushway, 1997). Other issues include frustration at the lack of opportunities for observing supervisors and other professionals modeling the work, while also critically assessing and evaluating the theoretical approaches (Rønnestad & Skovholt, 2003). What was found helpful during this stage included adequate supervision, modeling by other practitioners, and developing an internal source of validation (Rønnestad & Skovholt, 2003).

**DMT intern experience at Columbia College Chicago.** At CCC's DMTC program, students' clinical experiences include a practicum and internship. There is an expectation for the student to explore working with different sites and populations to facilitate a diverse clinical experience while an intern. The responsibilities/expectations of the student during the practicum and internship are different.

***Practicum.*** The practicum experience occurs over the course of approximately three months in the summer, between students' first and second year in the program. The practicum experience for the DMTC program's students represents Rønnestad and Skovholt's (2003) beginning student phase. During the practicum, it may be some students' first clinical experience

or first clinical experience with DMT. The expectations of the practicum primarily focus on helping students introduce themselves to clinical work as a dance/movement therapist through observation of supervisors and other staff on-site. Eventually, student interns start co-facilitating or leading therapy sessions (groups, individuals, family, couples, etc.). Students are also expected to begin to translate DMT theory into practice, recognize ethical concerns, and create an effective supervision environment (Allen, 2015). The total number of hours required for the practicum is 200, including 24 hours of academic supervision. Students are also expected to engage in site visits with their academic supervisors from CCC. This provides academic supervisors the opportunity to directly observe student interns facilitating DMT with actual clients. Observing student interns in a clinical context can guide supervisors to provide more nuanced, specified feedback and increase understanding of what support individual students need. Sites that have board certified dance/movement therapist (BC-DMT) require one site visit, and sites with a registered dance/movement therapist (R-DMT) require two site visits.

***Internship.*** The internship experience typically occurs during the fall and spring semesters of students' second year in the program. The internship experience for the DMTC program's students represents an overlap of Rønnestad and Skovholt's (2003) beginning student phase and advanced student phase. The responsibilities of student interns shift to independently practicing and applying the theory and skills learned during class and facilitating regular therapy sessions. Students are developing more advanced clinical skills in verbal counseling and DMT while exploring different theoretical approaches (Allen, 2015). Students are expected to develop competence and confidence as a dance/movement therapist, adhere to ethical standards of the American Dance Therapy Association (ADTA) (2015) and American Counseling Association (2014), and provide an in-service for the site's personnel (Allen, 2015). The total number of

hours required for the internship is 700: 350 hours of direct client contact (150 hours of DMT sessions), 350 hours of other clinical responsibilities, including 70 hours of supervision with a BC-DMT. Site visit requirements during internship will vary depending on whether or not the site has a BC-DMT supervisor or R-DMT. Sites with a BC-DMT supervisor will require one site visit per semester for a total of two. Sites with a R-DMT supervisor will require three site visits in the fall semester and two site visits in the spring semester for a total of five.

***Alumni experiences.*** Alumni of CCC's DMTC program have reported challenges in their clinical experiences similar to the literature on interns in other helping fields. Specific challenges DMTC students faced included lack of confidence in their role as a DMT intern, discomfort with assertion, not prioritizing self-care, feeling isolated, fearing judgment of incompetency by acknowledging difficulties, overreliance on external validation, fears of being wrong, unrealistic expectations of self and therapy, inability to create healthy boundaries with clients, unresolved issues in personal history, self-sacrificing behaviors, inadequate supervision, and an inability to recognize signs and symptoms of the possible risks of being a therapist (Blazek, 2010; Chapman, 2013; Copeland, 2013; Lengerich, 2001; Melius, 2013; Munnell Trif, 2010).

When recounting their experiences, interns coped with the potential risks in a variety of ways. Some interns indicated that they began to prioritize self-care and developing their own self-care process (Blazek, 2010; Chapman, 2013; Copeland, 2013; Melius, 2013; Munnell Trif, 2010; Sobolewski, 2007), but one intern indicated that the cumulative effects required them to take a leave of absence from the DMTC program to recuperate (Munnell Trif, 2010). Blazek (2010) said that by the end of the internship experience, she had not mastered all the skills of being a therapist, but she felt adequately prepared to step into a professional realm and continue cultivating her skills. Copeland (2013) used self-compassion to enhance her self-care practice,



which helped her remain self-regulated and form healthier relationships with her clients. This new resource for self-care was beneficial to Copeland (2013) as a student and saw its benefits as an emerging professional. Munnell Trif (2010) stated that, with distance and time to recuperate, she reframed her experiences and recognized that her professional development was going to be a lengthy process, but her internship had provided a foundation for her professional career in DMT. The clinical experience for DMT students is a rigorous, challenging path to becoming a professional and self-care proved essential for each of these individuals in their professional development of becoming dance/movement therapists.

### **Possible Risks of Being a Therapist**

When choosing to work as a therapist, a person is susceptible to possible risks, including burnout, compassion fatigue, unresolved countertransference, unresolved somatic countertransference, therapist distress, and vicarious traumatization. This is not an exhaustive list of the potential risks a therapist may face, but these are highly documented terms within the literature. As mentioned previously, novice therapists and student interns are highly susceptible to these risks for numerous reasons, including lack of professional experience, unrealistic expectations, stress about evaluations, and balancing multiple life roles (Cushway, 1997; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003).

These risks relate to a therapist's essential tool: empathy (see Appendix A). Empathy is considered to be one of the most effective tools for therapists as it helps to establish therapeutic relationships and provides opportunities for insight into a client's experience (Blazek, 2010; Figley, 2002; Munnell Trif, 2010; Rothschild, 2006). For a dance/movement therapist, the use of kinesthetic empathy (see Appendix A) often goes hand-in-hand with the more traditional understanding of empathy. Not only do dance/movement therapists attune with a client's

experience through verbalization, but also through observations of the body and somatic attunement experiences (Chapman, 2013; Copeland, 2013; Forester, 2007; Melius, 2013; Munnell Trif, 2010). When empathy, in any form, is used consciously by the therapist it is an invaluable tool. However, as Rothschild (2006) reminded, when empathy is used unconsciously by therapists, it increases the chances of experiencing the risks of being a therapist.

Within therapists' professional lives, experiencing any of these risks does not indicate incompetence, and it is often considered normal to experience to some degree (Kottler, 2010; McCann & Pearlman, 1990; Norcross, 2000). Although experiencing any of these to an extreme would preferably be avoided, many therapists will experience these possible risks. Rather than reinforcing stigma by telling student interns to avoid these risks completely, it is important to reduce the severity of symptoms and focus prevention of future occurrences.

A concern with the literature and research around these potential risks of being a therapist is the overlapping and unclear definitions of several of these terms. Although some terms have fairly consistent definitions across different authors and researchers, such as burnout, many definitions tend to conflict or overlap. For the purpose of this thesis, I have operationalized certain definitions (see Appendix A) and compiled a list of symptoms and factors for each of the risks of being a therapist (see Appendix B).

**Burnout.** Burnout (see appendix A) is one of the possible risks of being a therapist, and can result in a therapist eventually leaving their profession if it is not addressed (Cummins, Massey, & Jones, 2007; Richards, Sheen, & Mazzer, 2014). Maslach (2003) defined burnout as, “a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems... what is unique about burnout is that the stress arises from the social interaction between helper and recipient” (p. 2). Burnout has

many different definitions throughout literature, but one widely agreed upon aspect that distinguishes burnout from other risks, is its gradual onset (Figley, 2002; Jacobson, Rothschild, Mirz, & Shapiro, 2013; Stamm, 2010). Over time, therapists will have personal and professional challenges that include physical, emotional, and psychological stressors. If therapists do not recuperate from these stressors, they may begin to experience burnout. Burnout increases the risk of therapists offering ineffective care to their clients, and also affects other areas of the therapist's life outside of their profession. Rothschild (2006) described how burnout manifests as an extreme reaction, such as a clinician's health deteriorating or their outlook on life turning cynical.

Symptoms of burnout will manifest differently for individual therapists, but research has found common signs that indicate the possibility of burnout. Factors that contribute to the onset of burnout can be environmental/organizational or originate from intrapsychic factors of the therapist (Baker, 2003). The developmental phase of the therapist can also make them more vulnerable to the effects of burnout, specifically for therapists who are young and/or inexperienced (Baker, 2003).

**Compassion fatigue.** The most basic definition of compassion fatigue is the experience of suffering as a result of helping or caring (Rothschild, 2006). The symptoms of compassion fatigue are similar to those of secondary traumatic stress or secondary traumatization (see Appendix A). Trauma (see Appendix A) is a familiar concept for therapists, and as trauma has become the focus of more and more research, its concept has developed into a more complex definition. Trauma is now recognized as a widespread phenomenon for many children, adolescents, and adults in the United States, and is often a precursor for a person entering into therapy or counseling (Substance Abuse and Mental Health Services Administration

[SAMHSA], n.d.). For people who witness or experience trauma firsthand, they may experience primary traumatization (see Appendix A). Examples of traumatic experiences include community violence, terrorism, sexual abuse, physical abuse, natural disasters, medical trauma, domestic violence, neglect, and school violence (National Child Traumatic Stress Network [NCTSN], n.d.).

As with other people, therapists may be exposed to traumatic events in their personal life at a personal level (e.g. having an abusive partner) or a community level (e.g. mass shooting). However, therapists are at a higher risk for secondary traumatic stress and secondary traumatization. Rothschild (2006) defined the terms secondary traumatic stress and secondary traumatization as the suffering that occurs as a result of being close to a person who experienced trauma, rather than being directly involved in the traumatic incident. The definitions for these terms vary in the field of psychology, and also tend to overlap with other risks of being a therapist, such as compassion fatigue (Rothschild, 2006). For the purpose of this thesis, compassion fatigue will be the operationally defined term used to account for these experiences.

Compassion fatigue is considered to be highly preventable and treatable, but it is also inherently related to the *cost of caring* (Diaconescu, 2015; Figley, 2002; Jacobson et al., 2013; Melius, 2013). The cost of caring is a term used to describe what resources therapists use needed to use empathy, such as the emotional energy required when empathizing with clients (Figley, 2002). When using empathy as a tool to enhance the therapeutic relationship, therapists bear the suffering of their clients to better understand past experiences (Figley, 2002). However, when therapists start to over-identify with clients and boundaries blur, there is an increased risk for developing compassion fatigue (Hughes, 2014). Indicators of compassion fatigue include a therapist's inability to attend to clients (Hughes, 2014), poor self-care practices and extreme self-

sacrifice (Richards et al., 2014), increased risk of professional impairment (e.g. misdiagnosis, poor treatment planning, abuse of clients) (Bride, Radey, & Figley, 2007), or experiencing symptoms similar to posttraumatic stress disorder (Figley, 2002).

Distinguishing compassion fatigue from other risks of being a therapist is difficult, but there are a few specific differences to note. One difference is that compassion fatigue has a faster onset and recovery from symptoms than burnout (Figley, 2002). The symptoms of compassion fatigue are often not solely connected to the therapist's direct experiences, as it arises from a preoccupation with another person's experience, which may exacerbate the therapist's personal history of trauma (Figley, 2002). Figley (2002) described the experience of compassion fatigue as "a state of tension and preoccupation with the traumatized patients" (p. 1435). This state emerges from the process of empathizing and witnessing the suffering, and may manifest as avoidance, numbing, or re-experiencing a client's trauma (Figley, 2002).

**Countertransference.** The term countertransference (see Appendix A) was developed in psychodynamic theory to describe an experience all therapists encounter when working with clients. Countertransference offers opportunities to gain further insight into a client's situation, and/or informs the therapist of a need to resolve past issues that surface in relation to specific clients (Baker, 2003). Symptoms of countertransference include the therapist over-identifying with the client and seeing themselves in the client (Figley, 2002), or it may manifest as emotional reactions or images (Baker, 2003; McCann & Pearlman, 1990). The choice to become a therapist inherently increases the risk of uncovering or rousing therapists' vulnerabilities and conflicts (Baker, 2003). Initially, it was considered negative for therapists to experience countertransference while working with clients, but opinion has changed to regard it as a common and informative experience for therapists (Baker, 2003; Forester, 2007).

**Somatic countertransference.** As the field of therapy has become more aware of the mind/body connection, therapists are encouraged to notice not only their emotional and psychological reactions to clients, but also how the body responds. Somatic countertransference (see Appendix A) occurs when a therapist's body is affected by their client and the client's material (Forester, 2007). Symptoms of somatic countertransference can range from sensations in the body to full-blown sensory experiences that combine the somatic, affective, and cognitive (Forester, 2007; Rothschild, 2006). One major concern with somatic countertransference is that it can happen unconsciously, and may not immediately be given the same attention as countertransference involving thoughts or feelings (Forester, 2007; Rothschild, 2006). Addressing somatic countertransference requires a therapist to utilize their awareness of the mind/body connection, and to incorporate this awareness into the practice of self-care (Forester, 2007).

**Vicarious traumatization.** As the field of therapy has become more familiar with the risks of being a therapist, the concept of vicarious traumatization (see Appendix A) has developed. While other risks specifically look at how the therapist is affected by their work psychologically and emotionally, vicarious traumatization also encompasses the experience of the body (Forester, 2007; Rothschild, 2006). Vicarious traumatization arises from the empathic connection between therapist and client, when the therapist is not able to maintain appropriate boundaries or recuperate from bearing witness to the client's suffering (Hughes, 2014; Kleespies & Dettner, 2000; Melius, 2013). The trauma becomes a reality for the therapist, as their nervous system relives the client's experiences of trauma beyond their sessions with the client and into their daily life (Forester, 2007; Rothschild, 2006). This is what distinguishes vicarious traumatization from other risks like compassion fatigue or somatic countertransference (Forester,

2007). The client's material begins to affect the therapist's cognitive schemas, interpersonal relationships, and other aspects of the therapist's life, and these disruptions can persist for months or even years beyond the work with the client (Baker, 2003; Forester, 2007; McCann & Pearlman, 1990; Melius, 2013).

**Therapist distress.** Therapist distress (see Appendix A) has become a large focus in the research on therapist self-care for two reasons (Baker, 2003). The first reason is to help therapists cope with numerous risks of their jobs and regain or maintain personal well-being; there is also an ethical concern for clients seeing distressed or possibly impaired therapists. Working as a therapist comes with a higher risk for personal distress, depression, and/or anxiety than other individuals, because of exposure to clients' traumatic or distressing experiences as seen by descriptions of burnout, compassion fatigue, and other risks. If the therapist does not actively utilize self-care, it is likely that distress can become an impairment (see Appendix A). Even if a therapist does not become impaired, consistent distress that is not addressed will likely affect the quality of care over time.

Symptoms of therapist distress act as a warning signal for the therapist (Baker, 2003). These symptoms can affect all parts of the therapist, including the physical, emotional, psychological, relational, and spiritual. How therapist distress develops for individual therapists will vary, but accounts for both the therapist's personal and professional life (Baker, 2003). Graduate students in training have their own factors that may contribute to therapist distress, including school-related stressors (e.g. exams, papers), disruption of social support, financial pressures, self-doubt, first-time experiences with clients, inadequate supervision, client distress, self-awareness of own issues, and other specific stressors (Cushway, 1997).

Therapists are human beings, but it is often assumed that therapists have their personal and professional lives completely under control, which can be a dangerous assumption. This belief can result in therapists feeling guilt or shame around admitting their personal feelings of distress, and perpetuates a cycle of distress that is harmful for therapists and their clients (Baker, 2003; McCann & Pearlman, 1990; Norcross, 2000). The possible risks of being a therapist all relate to therapists' most vital tool – empathy. Empathy requires therapists to attune to their clients, which has a toll emotionally, psychologically, and physically. This toll may eventually develop into therapist distress, which is a normal experience, especially for novice clinicians (Baker, 2003; Turner et al., 2005). However, if therapist distress remains unchecked, there is an increased likelihood of it developing into an impairment or another risk of being a therapist. The way for therapists to prevent distress from spiraling into something more severe is self-care.

### **Self-Care**

Self-care has been defined in several ways in the literature, with some definitions being general while others are specific to an author. At times, self-care is defined vaguely as actions or experiences to maintain well-being (Bradley, Whisenhunt, Adamson, & Kress, 2013), behaviors that balance the effects of physical and emotional stressors (Richards et. al, 2014), or an integration of the parts of a person's wellbeing including physical, mental, emotional, and spiritual (Lengerich, 2001). For the purpose of this thesis, self-care is defined as, "The processes of self-awareness and self-regulation and the balancing of connections among self (involving the psychological, physical and spiritual, as well as the professional), others (including personal and professional relationships), and the larger community (encompassing civic and professional involvement)" (Baker, 2003, p. 13-14).



Self-care encompasses multiple facets of the Self within personal and professional contexts, such as the physical, emotional, spiritual, mental, and relational. The process of developing self-care occurs over a person's lifetime and changes as the needs of the person change, such as stage of life or stage of professional development (Baker, 2003). Developing a self-care practice is an individualized and personal process; what is helpful for one person cannot be generalized to be helpful for all others (Baker, 2003; Cushway, 1997; Skovholt, Grier, & Hanson, 2001). An important component of developing an effective self-care practice is the use of self-awareness (Baker, 2003), so a person can increase understanding of their individualized needs and determine what types of activities are helpful or not helpful. A common barrier when developing a practice is the ability for therapists to see themselves as worthy of self-care. If a therapist does not believe they are deserving of self-care, this may prevent them from actively engaging in the process. There are numerous other barriers to self-care, such as finding the time, money, and energy to invest into a practice, which are examined further in the discussion chapter.

Self-care is believed to be especially important for therapists and those in helping fields, because of the numerous risks that can be encountered in the work (Baker, 2003; Lengerich, 2001; Richards et al., 2014; Rothschild, 2006; Turner et al., 2005). Over time, research has looked at the need for self-care, and although the need is identified, there are often not specific options for its application. There is currently an overwhelming amount of resources about self-care, which can make developing a self-care practice difficult for student interns and novice therapists, who are already short on time and energy with their multiple commitments (Turner et al., 2005). It is recommended that self-care education be included in the graduate training experience for therapists, so that it can be prioritized early in students' professional development

(Baker, 2003; Turner et al., 2005; Weiss, 2004). Although creating a self-care practice is an individualized process, it can be helpful to offer graduate students resources with specific ideas for self-care activities to explore and determine what is most effective for their individual practice (Copeland, 2013; Turner et al., 2005).

**Defining the multifaceted self.** Using Myers and Sweeney's (2005) The Indivisible Self model and Maslow's Hierarchy of Needs (McLeod, 2007), it can be seen that there are multiple parts of the self, which need to be addressed when it comes to self-care, as they are often interrelated in a complex way.

***The Indivisible Self model of wellness.*** The Indivisible Self model (see Appendix C) is an evidence-based, strengths-based, holistic representation of different factors of the self, each factor's needs, and the contextual factors surrounding the individual (Myers & Sweeney, 2005). Myers and Sweeney emphasized that this model is choice-oriented, so it is the individual's responsibility to establish an intentional practice of wellness behaviors. Myers and Sweeney's model demonstrates what their research found was characteristic of healthy people based on "characteristics that correlated positively with healthy living, quality of life, and longevity" (p. 270). So this model translates easily into a discussion about self-care.

This holistic perspective assumes an individual's body, mind, and spirit are interconnected and inseparable when pursuing health (Myers & Sweeney, 2005). This concept is essential to the Adlerian theory, which the Indivisible Self model is based on, and is a theoretical assumption for DMT theories (Adler, 1931; American Dance Therapy Association, n.d.). This pursuit towards wellness involves internal elements of the Self; however, these factors are not isolated from an individual's environment. Myers and Sweeney (2005) highlight how the individual is simultaneously affected by and affects their environment. Our individual self affects

and is affected by the environments around us that range from our immediate contexts (e.g. home, workplace) to influences from society (e.g. politics, societal expectations) (Adler, 1931; Myers & Sweeney, 2005).

One example of how a factor, the factor's needs, and context interact follows. When considering a person's physical Self, one need is nutrition (Myers & Sweeney, 2005). The ability to meet this need is influenced by an individual's local, institutional, and global contexts. An individual may live in a neighborhood that is a food desert, an area lacking access to fresh foods (American Nutrition Association, 2011); which tend to arise from institutionally racist and classist policies and patterns of development in urban environments (Bower, Thorpe, Rohde, & Gaskin, 2014). Rather than assuming this individual would have the same access to resources as another person, the Indivisible Self model of wellness emphasizes the reciprocal relationship between an individual and their environment.

Within this model, self-care is one of the parts of the Essential Self, in addition to spirituality, gender identity, and cultural identity (Myers & Sweeney, 2005). Including self-care within the factor entitled the Essential Self, indicates the authors not only considered self-care important, but a necessary component to achieve a holistically healthy life. Myers and Sweeney define self-care as "proactive efforts to live long and live well" (p. 273). The authors believed avoiding or carelessly attending to self-care were signs of despair and of the loss of a sense of purpose in life.

***Maslow's hierarchy of needs.*** Maslow's Hierarchy of Needs (see Appendix C) considered multiple parts that comprise the Self and how a person's needs influenced their behaviors (McLeod, 2007). This information was then organized into a staged structure, which Maslow believed operated in a linear fashion. Maslow believed every person was capable of

moving through all eight stages, but that movement through the stages is not a linear process. Maslow believed that all people have basic needs that were necessary to address before more complex needs could be considered. Recent research has disagreed with Maslow's belief that you cannot move to higher levels of the hierarchy without meeting basic needs, as exceptions have been observed throughout the world. McLeod stated, "Also, many creative people, such as authors and artists (e.g. Rembrandt and Van Gough) lived in poverty throughout their lifetime, yet it could be argued that they achieved self-actualization" (2007, Critical evaluation, para. 9). The progression through Maslow's hierarchy may vary from individual to individual; some people may require meeting basic needs before progressing further while others may be able to move throughout the hierarchy without meeting their basic needs. Although the literature may disagree on how people progress through the hierarchy, the model has been found to depict universal human needs across cultural differences (McLeod, 2007), and his model can be used to inform a holistic self-care approach.

**Types of self-care.** Within the literature of self-care, many authors apply a multifaceted approach to self-care practices and explore specific forms of self-care (Baker, 2003; Cummins et al., 2007; Diaconescu, 2015; Lazarus, 2000; Lengerich, 2001; Myers & Sweeney, 2005; Norcross, 2000; Richards et al., 2014; Sapienza & Bugental, 2000; Skovholt et al., 2001; Turner et al., 2005; Weiss, 2004). Each form of self-care can address an individual's needs holistically by helping individuals avoid attending to only one aspect of their whole self. These forms and practices have been described within different categories for self-care by several authors, however I chose to use two categories: professional self-care and personal self-care.

**Personal.** Personal self-care is focused on activities that are done in the student's personal time, outside of their internship or professional context. Personal self-care practices may intersect with professional self-care practices, but this form of self-care is more focused on the student practicing self-care throughout all contexts of their life (see Figure 1 below).



*Figure 1.* Components of Personal Self-Care

**Physical.** Physical self-care revolves around care of the body. The types of activities that fall under physical self-care usually include Maslow's basic needs of air, food, drink, shelter, warmth, sex, and sleep (McLeod, 2007). While Maslow's list is fairly comprehensive, physical self-care activities also go beyond meeting the minimum for each of these needs to survive ensuring the physical self is truly cared for. Examples of physical self-care also include controlling and moderating substance use, healthy eating and nutrition, hiking, jogging, massage, medical care, physical exercise, relaxation techniques, stretching, tai chi, walking, and yoga (Baker, 2003; Davis, Robbins Eshelman, & McKay, 2000; Diaconescu, 2015; Fagnoli, 2014; Richards et al., 2014).

*Psychological.* Tending to our psychological self involves caring for our mental and cognitive processes and providing psychological nurturance (Baker, 2003; Richards et. al., 2014). This may involve finding different ways to stimulate the mind, seeking open-mindedness, and examining how healthy or unhealthy our thought processes are. Examples of psychological self-care include avoiding wishful thinking and self-blame, controlling empathic imagery, intentional distraction or diversion, normalizing experiences as a therapist (e.g. experiencing burnout, compassion fatigue), recognizing defense mechanisms, personal therapy, recognizing signs of distress/impairment/burnout/etc., increasing self-awareness, and increasing self-worth (Baker, 2003; Cushway, 1997; Kottler, 2010; Melius, 2010; Norcross, 2000; Rothschild, 2006; Turner et al., 2005).

*Emotional.* Tending to our emotional self involves tuning in to our emotional processes, noticing how self-care choices influence our emotions, and how we express our emotions. Differentiating between emotional and psychological processes is impossible at times as these processes are interconnected (Pessoa, 2008). Siegel (2012) differentiated between cognitive and emotional processes by defining emotions as “changes in the state of integration” (p. 148). If a person perceives an event to be negative, their state of integration will shift to experience disharmony, which may manifest as emotional distress (Siegel, 2012). Examples of emotional self-care include creating affirmations, acknowledging and working through difficult experiences, balancing feelings of loss and joy, grieving, humor, journaling, personal therapy, creative activities, pleasurable activities (e.g. cooking, reading, hobbies, traveling), and allowing for free time (Baker, 2003; Davis et al., 2000; Fagnoli, 2014; Lengerich, 2001; Sapienza & Bugental, 2000; Turner et al., 2005; Weiss, 2004).

*Spiritual.* The spiritual self helps people connect to a higher purpose or find meaning in life, whether through a specific spiritual/religious practice or not. This aspect of therapist self-care has more recently been emphasized (Baker, 2003; Rothwell, 2006), whereas a negative stigma surrounded the idea of therapists and spirituality for many years (Behere, Das, Yadav, & Behere, 2013). Examples of spiritual self-care include connecting to a higher power, connecting to the human experience, using meditation and/or prayer, being in nature/outdoors, religious practices, and creating personal spiritual rituals (Agor, 2003; Baker, 2003; Mahrer, 2000; Rothwell, 2006; Weiss, 2004).

*Relational.* The relational self involves the therapist's relationship to self and others. Understanding how relationships can nurture or hurt is important, as is finding ways to be connected to others in a smaller (e.g. family, friends, partners) or larger (e.g. community, global) sense. Different forms of relational self-care include establishing boundaries, acting assertively, developing autonomy, balancing care for self and other, developing self-compassion, developing healthy self-needs, finding a mentor, using positive self-talk, spending quality time with others, developing self-acceptance, having social support (e.g. colleagues/peers, family, friends, mentor, supervisor, support groups, virtual community), and receiving supervision (e.g. with supervisor, with peers/colleagues) (Baker, 2003; Brooks, Holtum, & Lavender, 2002; Figley, 2002; Richards et al., 2014; Skovholt et al., 2001; Turner et al., 2005).

*Professional.* Professional self-care practices are focused on activities that an intern can practice in the context of their internship site. Different components included under personal self-care (physical, emotional, psychological, spiritual, and relational) are also present in professional self-care activities. Professional forms of self-care may include accepting a lack of closure, assessing personal triggers, managing time and workload, referring clients if

overwhelmed/triggered, creating a good work environment, diversifying professional activities, taking vacations/leaves of absences, seeking out further training, practicing ethically, quitting an unsatisfying job, setting intentions, and savoring moments of external validation (Baker, 2003; Hughes, 2014; Norcross, 2000; Osborn, 2004; Rothschild, 2006; Skovholt et al., 2001; Turner et al., 2005).

## **Conclusion**

The importance of self-care for therapists is well-recognized in the literature, as demonstrated by Cummins et al. (2007), “The essence of counseling is to consistently summon the energy to engage with another human’s emotions while at the same time balancing our own personal experiences and challenges outside of the job” (p. 35). As more research has focused on therapist self-care, literature has emphasized the need for emerging therapists to develop their self-care practice early in their training (Baker, 2003; Turner et al., 2005; Weiss, 2004). However, a distinct gap within the literature is providing student interns with concrete examples of self-care activities to facilitate this experimental process. Literature focused on self-care and DMT student interns is mostly comprised of self-studies, in which individuals discovered and offered self-care ideas for future student interns (Blazek, 2010; Chapman, 2013; Copeland, 2013; Corbi, 2005; Harris, 2009; Munnell Trif, 2010; Olson, 2006; Sobolewski, 2007). These studies can be used to provide student interns with a limited amount of ideas to attempt, but the scope of these research studies was not focused on providing a more comprehensive list of options to other individuals.

This thesis intends to provide future DMT student interns with self-care tools that are comprehensive and focused on application rather than theory. In addition, an intention to approach self-care holistically led to the creation of products to help address the multifaceted



needs of an individual. The questions that guided my process were: What self-care activities are most effective for DMT student interns at Columbia College Chicago? What would a multifaceted self-care tool look like for DMT student interns? What body-based self-care activities are most effective for DMT students at Columbia College Chicago? This thesis project will help to fill the gap in the literature by providing future DMT student interns with self-care ideas that are concrete, comprehensive, and holistic.

## **Chapter Three: Methods**

### **Methodology**

The methodology used for this thesis was the Eight Stage-Gate Process for New Product Development. This best practice methodology was developed by Robert G. Cooper based on his research into the success and failure of products (Grönlund, Sjödin, & Frishammar, 2010; Martin, 2014). The Stage-Gate process is simultaneously conceptual and operational; focused on developing a product from an idea to a concrete product (Grönlund et al., 2010). This methodology is typically utilized by companies developing products in large quantities. Parts of the Stage-Gate process were adapted to align with the purpose and scale of this thesis. Any modifications to the methodology will be noted in the procedure and a rationale for what was altered or excluded is given.

While using the Stage-Gate Process methodology, I used the pragmatism paradigm. This paradigm aligned with this thesis because it is focused on practicality of the product and resulted in real-world practice as opposed to theory generation (Mertens, 2015). The criterion for this thesis is effectiveness, which is defined as, “establishing that the results ‘work’ with respect to the specific problem that the research seeks resolution of” (Mertens, 2015, p. 37). Effectiveness was defined by the participants in this project and it is acknowledged the definition of effectiveness will vary from person-to-person. The choice to use mixed methods to collect input from participants also aligns with this paradigm. In order to best answer the guiding questions, both quantitative and qualitative input was obtained from participants and used in the generation of ideas and product development (Mertens, 2015).

## **Participants**

The participants in this project were contacted to partake in an online survey and included alumni and students interning at the time of survey distribution. Alumni and students were connected to CCC's DMTC program and solicited through an email database created by the department to assist thesis research. The alumni and students contacted were asked to report on their experiences as a DMT intern while at CCC. A total of 125 alumni and students were emailed a request to participate in the survey, which included 111 alumni and 14 current students. The response rate for the survey was 49% with 69 respondents (56 alumni and 13 current students). 61 respondents submitted a completed survey, and 8 respondents submitted an incomplete survey. Surveys were considered incomplete when respondents did not answer all required questions. The incomplete survey responses were not able to be used and input was not included in the results.

**Recruitment of survey respondents and focus group.** An online survey was sent to alumni and current students in CCC's DMTC email database. The email database was comprised of alumni who volunteered to participate in thesis research by students in CCC's DMTC program. Participants self-selected whether or not to participate in the survey, and were offered a small, reasonable incentive to encourage responses to the survey. The incentive was an opportunity to win one of four Amazon.com gift cards valued at \$25. The gift cards were randomly selected in a drawing once the survey was closed to responses. To protect the identity of survey respondents, no identifying information was collected in the survey. Respondents who volunteered to be part of the gift card drawing were required to submit limited information (name and email) on a separate survey to avoid pairing a respondent with their survey answers.

Focus group participants were recruited through a similar process to the survey. An email invitation was sent out to alumni and current students of CCC's DMTC program and participants self-selected whether or not to participate. A continental lunch was provided as an incentive for focus group participants. Initially, 10 people volunteered to participate in the focus group and six participants attended the focus group. Four volunteers were unable to attend the focus group because of scheduling issues or other difficulties. The focus group was comprised of one DMTC faculty member, three DMTC alumni, and two current DMTC students.

**Setting.** Data was collected through an electronic survey and literature review. Meaning-making processes and the focus group occurred in my personal residence.

## **Procedure**

The Stage-Gate process consists of eight stages: 1) idea generation, 2) idea screening, 3) concept development, 4) business analysis, 5) beta and market testing, 6) technical implementation, 7) product launch, and 8) new product pricing (Martin, 2014). Grönlund et al. (2010) described the stages as a time designated for essential activities to be completed and specific activities depend on the stage, such as generating ideas, manufacturing prototypes, and analyzing survey data. At the end of each stage is a gate, essentially a checkpoint, which serves as an opportunity to review and evaluate what has been achieved in each stage (Grönlund et al., 2010).

Idea generation is focused on brainstorming to transform an abstract concept into ideas for concrete products (Martin, 2014). The idea generation stage began during a thesis seminar course when refining my thesis proposal. I knew the topic of self-care was important to me personally, as I was fighting against my own symptoms of burnout and compassion fatigue. However, my initial idea was reinforced by a 100% response rate to a pilot project survey

focused on learning about my classmates' self-care habits. It was evident that the topic of self-care was important to my peers and more information on self-care was desired, as my classmates and I were immersed in a rigorous and difficult year. The general concept of my thesis formed and I decided to create products focused on self-care for DMT student interns.

**Collecting external input.** The collection of external input and meaning-making processes occurred simultaneously during this project. In order to create products that would be helpful to as many DMT student interns as possible, I collected external input from alumni and current students of CCC's DMTC program. An online survey (see Appendix D) was the primary mode of collecting input. The questions in the survey collected qualitative and quantitative input related to respondents' prior experiences as interns at their practicum and internship sites, experiences with possible risks of being a therapist while interning, self-care practices as student interns, and what self-care products would have been helpful as student interns. The survey included definitions of important terms (e.g. burnout, compassion fatigue, vicarious traumatization) if participants were unfamiliar with a specific term. All activities reported by participants, including activities that may be judged as unhealthy or counterproductive, which is reviewed in the discussion chapter. The collection of external input concluded the first stage of idea generation and transitioned my process into the second stage - idea screening.

Idea screening is the time to develop criteria for the product ideas; determining what is achievable and what is not (Martin, 2014). The criteria for the development of these products were: relevance, accessibility, and investment requirements (e.g. time, effort, and finances). My products would need to be relevant and accessible to the target audience (future DMT student interns).

I took suggestions from the survey respondents and compared their suggestions to my criteria. Respondents indicated what products would have been relevant and helpful to them as student interns in the survey. Ideas for possible products were provided, such as a book, website, workshop, or podcast. Looking over the results of the survey, two products were suggested by the majority of respondents – a website and booklet. These two products met all of the criteria and my process transitioned into the third stage of concept development and testing.

Concept development and testing is focused on what the consumer understands, wants, and needs from a product or service (Martin, 2014). My survey informed me how respondents defined, related, and used self-care. It also highlighted patterns in their self-care practices, such as not attending to all parts of the Self and feeling unable to access self-care due to a lack of resources. The majority of respondents reported that they considered it important or very important to develop a self-care practice in graduate school; indicating the desire for these types of products. Another part of stage three was to apply meaning-making processes to the collected input, which is described later in this chapter.

The fourth stage of this methodology is business analysis, which focuses on assessing a product's potential profitability (Martin, 2014). This stage was omitted because determining profit was irrelevant when considering the purpose of this thesis. For this project, parts of stage four were blended into earlier stages as it felt appropriate, so the next stage in my process was stage five – beta and marketability testing.

I outlined the basic design of my two products and created prototypes, which brought me into the fifth stage of beta and marketability testing. The use of focus groups is common within this stage and aims to provide feedback and constructive criticism about a product (Martin, 2014). A focus group was held in my residence to review my two product prototypes, and my

role was moderator. As moderator, I facilitated discussion and documented feedback from each participant (Gibbs, 1997). The feedback from the focus group identified product features that were useful or irrelevant and hypothesized when the products would be most useful for the target audience. Following the focus group, I moved into stages six and seven as I revised and made preparations to release the products.

The sixth stage focused on requirements for technical implementation, which translates to finalizing the methods of production and distribution of the product (Martin, 2014). This involved determining what services to use for the creation of the booklet and website, which was done through personal research and comparison of available options for printing and website building. I transitioned into the seventh stage – the product launch – resulting in my self-care tools being available to the DMTC students at CCC.

The finalized products were a 29-page booklet and website. An electronic copy of the booklet was finalized and stored with the electronic copy of this thesis at CCC. A physical copy of the booklet was printed through FedEx, and is available for use in CCC's DMTC office. The website was created through the website builder Wix and is able to be viewed at [www.dmtselfcare.com](http://www.dmtselfcare.com).

The eighth stage of this methodology is the post launch review. Parts of this stage are outside of the scope of this thesis, including assessing the impact of the product after distribution, reassessing pricing, and tracking marketing trends (Martin, 2014).

**Approach to meaning-making.** The external input collected was examined through two meaning-making processes: statistical analysis was used for quantitative input and summative content analysis for qualitative input.

***Quantitative input.*** The sample size was 61 respondents from a population of 125 survey recipients. The survey asked participants about background information (e.g. age and professional experience), experiences with symptoms related to the possible risks of being a therapist, individual self-care practices (e.g. frequency, specific activities included or excluded, effectiveness of practice), categories of self-care used in their practices, and opinions on the importance of self-care as a student intern. Graphs were created in Microsoft Excel program to represent the quantitative input and are presented in this thesis' findings chapter.

***Qualitative input.*** Qualitative input was also gathered from participants in the form of open-response questions. These questions asked about specific self-care activities individuals included or excluded from their self-care practice, reasons for including or excluding self-care activities, self-care resources used, and what self-care products respondents wish had been available when interning. Summative content analysis was used to examine the qualitative input.

Summative content analysis focuses on exploring essential elements within text and using latent content analysis to interpret the importance of the text (Hsieh & Shannon, 2005; Rapport, 2010). The first step in this process was to ascertain the frequency of identified words with an online text analyzer to determine what content was essential text (Rapport, 2010). Rapport (2010) defined essential text as “elements of the text that offer a point of entry into the meaning of the whole text, and that give the text its import” (p. 273). After identifying the essential text, I created a content-analytic summary table (see Appendix E). The content-analytic summary table was used to display all related and relevant input from multiple surveys into a single form (Miles & Huberman, 1994). Using the content-analytic summary table, I was able to transform the essential text from the survey into categorized themes that influenced the creation of the self-care products. These categorized themes were created from examining what types of self-care



activities were used when coping with specific risks of being a therapist experienced by survey respondents. The themes were categorized by type of self-care, which include *physical*, *psychological*, *emotional*, *relational*, *spiritual*, and *professional*. A total of 23 subthemes were found from this process; a few examples include *basic needs*, *physical activity*, *creative activities*, *leisure activities*, *body/mind practices*, *social support*, *spiritual activities*, *thought processes*, and *therapy*.

**Validation strategy.** The validation strategy used in this project was a focus group. Focus groups are organized discussions with a group of selected individuals to gain insight and understanding of their perspectives and experiences with a topic (Gibbs, 1997). This focus group was comprised of one DMTC faculty member, three DMTC alumni, and two current DMTC students from CCC. An invitation was sent out to alumni and current students from CCC's DMTC program, and recruited five recent alumni and current students for the focus group. A DMTC faculty member was directly invited to expand the perspective of the focus group, and include input from an individual with long-term professional experience, as well as novice professional and intern perspectives.

The members of the focus group were gathered to provide feedback on the self-care products created. Participants discussed the website and booklet providing feedback related to both products' visual appeal, usability, and relevance. Focus group participants offered additional suggestions for each of the products, such as ideas for improving the overall product design and when to offer these products to the target audience. The feedback and suggestions obtained from the focus group were used to revise the products, and these revisions will be discussed in more detail in the discussion chapter.

## **Ethical Considerations**

The prominent ethical considerations in this project were confidentiality and the planned use of incentives. Steps were taken to ensure confidentiality for participants of the survey and focus group. Survey participants were not asked to provide any identifying information aside from their age(s) when DMT student interns at CCC and brief responses about their career experiences. To avoid an accidental disclosure of a survey respondent's identity, a completely separate survey was created for the gift card drawing and asked only for the name and email of the respondent. The raw data will be discarded within five years of submitting this thesis. The use of incentives for this project were limited to reasonable compensation, such as the possibility of winning a \$25 gift card from Amazon.com and continental lunch for participating in the focus group.

## **Chapter Four: Findings**

This project focused on the creation of multifaceted self-care products for future DMT student interns. The guiding questions for this project were: What self-care activities are most effective for DMT student interns at CCC? What would a multifaceted self-care tool look like for DMT student interns? What body-based self-care activities are most effective for DMT students at CCC? The term finding is used, as opposed to result, because the gathered data were not outcomes of a specific intervention or strategy. The external input gathered for this thesis existed prior to this project, and this thesis focused on creating potential resources rather than meeting specific outcomes for change. The mixed format presentation of the findings answers the guiding questions, and includes presentation of themes from qualitative input, statistics from quantitative input, and the creation of two products: a booklet (see electronic booklet included with this thesis) and website (see [www.dmtselfcare.com](http://www.dmtselfcare.com)).

### **Qualitative Findings**

The qualitative findings were categorized into major themes and subthemes, which are presented in the content-analytic summary table (see Appendix E). The survey asked respondents to describe self-care activities used when they reported experiencing one (or more) of the risks of being a therapist. Through the use of text analysis, it was found many of the self-care activities correlated with the categories of self-care found within the literature review. The six themes identified were:

(1) *Physical*: caring for the physical body by fulfilling basic needs, utilizing body/mind practices, attending to nutrition/substance use, and being physically active.

(2) *Emotional*: attending to the emotional Self by participating in creative activities, expressing emotions through various outlets, and enjoying leisure activities.

(3) *Professional*: caring for the Self within a professional context by utilizing body/mind practices, making changes to their work environment, adjusting expectations, using interpersonal support, and managing time.

(4) *Relational*: finding connections to others and Self by exploring relation to self, having sex, and seeking social support.

(5) *Spiritual*: pursuing or experiencing a connection to something larger than oneself by seeking spiritual support and participating in various spiritual activities.

(6) *Psychological*: caring for the mind through the use of body/mind practices, furthering education, examining thought processes, simplifying, and attending therapy.

The themes and subthemes have complex relationships, and the use of certain subthemes will occur within multiple themes, such as the subtheme of body/mind practices. An example of this is yoga. Technically, yoga could be considered a form of physical self-care, as it is movement and physical activity, but it is also used to connect with spirituality. It is difficult to capture the complexity of how specific self-care activities correlate to multiple categories of self-care. For the purpose of this thesis, self-care activities were categorized based on the expressed intention for the activity presented in survey responses and the literature.

**(1) Physical.** The most commonly used self-care activities reported by survey respondents fell under the category of physical self-care. Various forms of physical self-care were used when respondents reported experiencing the risks of being a therapist, and it was the most frequently reported category. A total of 234 activities mentioned fell under the physical category, which was organized into four subthemes: *basic needs*, *body-based practices*, *nutrition/substance use*, and *physical activity*.

**Basic needs.** Several respondents reported that meeting basic needs was part of their self-care practice as an intern. Self-care activities classified as basic needs included sleeping/napping, resting, staying hydrated, and maintaining hygiene. These activities are categorized as basic needs as categorized by Maslow's Hierarchy of Needs, such as air, drink, shelter, etc. (McLeod, 2007). Respondents also consistently mentioned these activities within the context of meeting the minimum required to function.

**Body-based practices.** The use of body-based practices to care for the physical Self was reported less frequently throughout the survey. Some self-care activities categorized under body-based practices included getting bodywork, receiving massages, recuperating by being active, going to a spa, and using aromatherapy.

**Nutrition/substance use.** Nutrition and substance use were commonly used self-care activities. Respondents often stated "eating healthy" or "proper nutrition" was part of their self-care practice, but also cited specific types of food or drink, such as desserts and tea. Nutrition was created into a distinct subtheme, because when mentioned, nutrition went beyond meeting the basic needs. Substance use was also mentioned by respondents, including drinking wine/alcohol and smoking.

**Physical activity.** The final, and most frequently used, subtheme (mentioned 117 times) was *physical activity*. Various types of physical activity were included under this subtheme, including biking, running, walking, going to the gym, stretching, and swimming. These types of physical activity were part of self-care, but also focused primarily on exercising the body as a way to improve physical health, strength, and flexibility. The benefits of physical activity extend beyond benefits to the body, but it was assumed the intention of these activities was predominantly focused on physical well-being.

**(2) Emotional.** The second most commonly used forms of self-care activities fell under the emotional category. A total of 182 activities mentioned were considered emotional self-care, which were organized into three subthemes: *creative activities*, *expressing emotions*, and *leisure activities*.

***Creative activities.*** Self-care activities that involved the creative process or tapped into an individual's creativity were used by several respondents. These types of activities included art-making, choreographing, dancing, drawing, listening to music, painting, and writing. Creative activities are included under emotional self-care, as they provide an outlet for emotional expression and have been found to increase feelings of happiness (Agor, 2003; Blazek, 2010; Richards et al., 2014).

***Expressing emotions.*** The subtheme of *expressing emotions* is an important component of emotional self-care. Finding safe ways to express emotions and providing space to feel and process emotions is helpful for therapists (McCann & Pearlman, 1990). Respondents of the survey mentioned journaling as one method for expressing emotions safely.

***Leisure activities.*** Leisure activities is a broad subtheme to capture the activities primarily focused on enjoyment and/or intentional distraction. These types of activities may include hobbies or other interests outside of school and/or work, such as baking, humor, watching movies or television, reading, spending time with pets, and shopping. These activities can engage the brain in a relaxed, fun way and provide intentional diversion from stress.

**(3) Professional.** The third most common form of self-care reported was professional self-care. Professional self-care encompasses all categories, but occurs within a professional context or is directly related to an individual's professional identity. A total of 179 activities mentioned were part of the professional category and organized into six subthemes of:

*body/mind practices, environmental, expectations, other professional activities, interpersonal, and time management.*

***Body/mind practices.*** Body/mind practices are defined as processes that believe the body and mind reciprocally affect each other. As an example, a positive change within the body can result in a positive change within the mind, or vice versa. Within the theme of professional self-care, body/mind practices were commonly used by survey respondents. Examples of body/mind practices include breathwork, grounding, vertical roll-downs, spatial boundary setting, and energy clearing rituals.

***Environmental.*** Although student interns may be limited in terms of influencing major changes to their internship site, survey respondents described the ability to make small changes to their environment as self-care. Examples of this included leaving their internship site during lunch breaks, unplugging from work-related technology (e.g. email), and immediately changing out of their clothes after internship.

***Expectations.*** Expectations for practicum and internship are laid out by student interns' course syllabi and DCAT's *Clinical Placement Manual*. However, various internship sites may have additional expectations of the student intern. Whether or not the intern can manage the additional expectations is dependent on the individual. Survey respondents reported adjusting or decreasing their responsibilities at internship as part of self-care. Adjustments may be temporary or permanent shifts in expectations or responsibilities.

***Other professional activities.*** Recuperating may also take the form of focusing on different types of professional responsibilities. One respondent stated using clinical documentation as a form of self-care, as it provided time for them to process their sessions in a different way. Although facilitating therapy sessions tends to be the main focus of student

interns, having the opportunity to experience other professional activities can be recuperative and informative.

***Interpersonal.*** The most frequently used professional self-care activity by survey respondents fell under the interpersonal subtheme. Many respondents emphasized the importance of supervision within academic and internship settings, including supervision with peers or a supervisor. The other self-care activity highly recommended by survey respondents was setting boundaries within the professional setting. This includes boundaries between the student intern and their clients, but may also involve setting other types of boundaries. Another type of boundary needed by interns could be setting boundaries to maintain work/life balance, such as learning how to leave without bringing work home.

***Time management.*** Time management was another one of the frequently mentioned subthemes within professional self-care. The self-care activities reported by survey respondents included scheduling time to eat lunch, taking breaks throughout the day, arriving early to prepare for the day, and adjusting hours if needed. This included time management while at internship, but also learning to manage time in a broader sense, such as planning time off. As student interns, the ability to schedule time off or vacations may be limited, but students are encouraged to discuss their options with internship site supervisors.

**(4) Relational.** Survey respondents reported using a total of 127 relational self-care activities, which included both intrapersonal and interpersonal relationships. Few respondents cited specific examples of relational self-care and respondents seemed to focus more on interpersonal relationships as self-care. The three subthemes for relational self-care were: *relation to self, sex, and social support.*



***Relation to self.*** A few respondents mentioned self-care activities focused on enhancing their relationship to the Self. This included intentionally making time to be alone, using self-touch (sexual and non-sexual), and accessing self-compassion regularly.

***Sex.*** Sex as a form of self-care was only mentioned four times by survey respondents. Respondents did not distinguish if they meant sex with a partner or alone, but both types are recommended by self-care literature (Baker, 2003).

***Social support.*** Although relational self-care was not the most common form of self-care for the survey respondents, *social support* was the second most frequently mentioned subtheme (cited 116 times). Several types of interpersonal relationships fell under *social support*, such as cohort/peers, colleagues, family, friends, instructors, and significant others. These types of relationships spanned across both professional and personal settings, but were distinguished from instances of supervision (categorized as professional self-care).

**(5) Spiritual.** The spiritual category was the fifth most used form of self-care according to the survey respondents. Spiritual self-care activities were mentioned 106 times and two subthemes were created: *seeking spiritual support* and *spiritual activities*.

***Seeking spiritual support.*** In the survey, the term “seeking spiritual support” was stated three times when coping with one of the possible risks of being a therapist. The term was not clarified by any respondents, so it was unclear how or where respondents were seeking spiritual support during their time as a DMT intern.

***Spiritual activities.*** Self-care activities reported by respondents included using affirmations, meditating, spending time in nature, praying, attending religious services, and practicing yoga. Respondents wrote about using these activities to connect to a sense of spirit or connecting to something larger than themselves (e.g. nature, God).

**(6) Psychological.** The least common form of self-care mentioned by survey respondents was psychological self-care. Psychological and emotional self-care are often not separated because of their reciprocal relationship (Myers & Sweeney, 2005), which may be a reason for these activities being the least reported. This will be examined further in the discussion chapter of this thesis. Psychological self-care activities were mentioned 94 times and organized into five subthemes: *body/mind practices*, *furthering education*, *simplifying*, *thought processes*, and *therapy*.

***Body/mind practices.*** Respondents mentioned practices that used the body/mind connection. However, respondents primarily emphasized the psychological benefits or focused on the top-down approach to these practices, so they were categorized under psychological self-care. Specific self-care activities under this subtheme included: mindfulness and relaxation exercises.

***Furthering education.*** Respondents mentioned methods of furthering their education as a form of self-care. The literature mentions furthering education as beneficial, whether a person chooses to continue learning about topics related to their career or topics unrelated to their career (Melius, 2013; Osborn, 2004; Weiss, 2004). Specific self-care activities mentioned from the survey were reading self-help books, continuing their education, and making time to read or watch the news.

***Simplifying.*** The subtheme of simplifying could be conceptualized in different ways. However, respondents directly mentioned the act of cleaning and organizing as a way to care for the self. Taking the time to organize the external environment can help make a person's internal experience feel more organized as well (Bourg Carter, 2012).

**Therapy.** Attending therapy was the final subtheme under psychological self-care, and has also been highly recommended within self-care literature (Baker, 2003; Blazek, 2010; Chapman, 2013; Copeland, 2013; Forester, 2007; Hughes, 2014; Kleespies & Dettner, 2000; Lengerich, 2001; Mahrer, 2000; Melius, 2013; Norcross, 2000; Osborn, 2004; Skovholt et al., 2001; Turner et al., 2005; Weiss, 2004). Specific ideas included the use of authentic movement within therapy sessions and seeking out a dance/movement therapist as a personal therapist.

### **Quantitative Findings**

The survey provided the opportunity for respondents to report relevant background information, experiences with the possible risks of being a therapist, and offered a glimpse into their self-care practice while DMT student interns. A total of 125 surveys were distributed online with a response rate of 49% (61 respondents). The design of this survey allowed respondents to skip questions that were not relevant to their experience, such as a specific risk of being a therapist. Due to this design, not all findings are statistically significant.

**Demographics and background information.** Respondents were asked to provide basic background information, including age, experience as a therapy intern, prior career experience(s), and prior experience in the field of mental health. When reviewing self-care literature, it was mentioned that age, stage of life, and professional developmental stage may influence an individual's self-care practice (see Figure 2 and Figure 3 below). During the early stages of this project, it was uncertain whether or not this information would influence the design or form of the products. This information was gathered, but ultimately did not influence the final versions of the products created for this thesis.

Eighty-five percent of survey respondents were between the ages of 20-29 years of age as DMT student interns at CCC. Fifteen percent of survey respondents were between the ages of

30-39 or 40-49 years of age as DMT student interns at CCC. The majority of respondents reported their first experience as a therapy intern was at CCC, and no prior career was established or experience in the field of mental health.

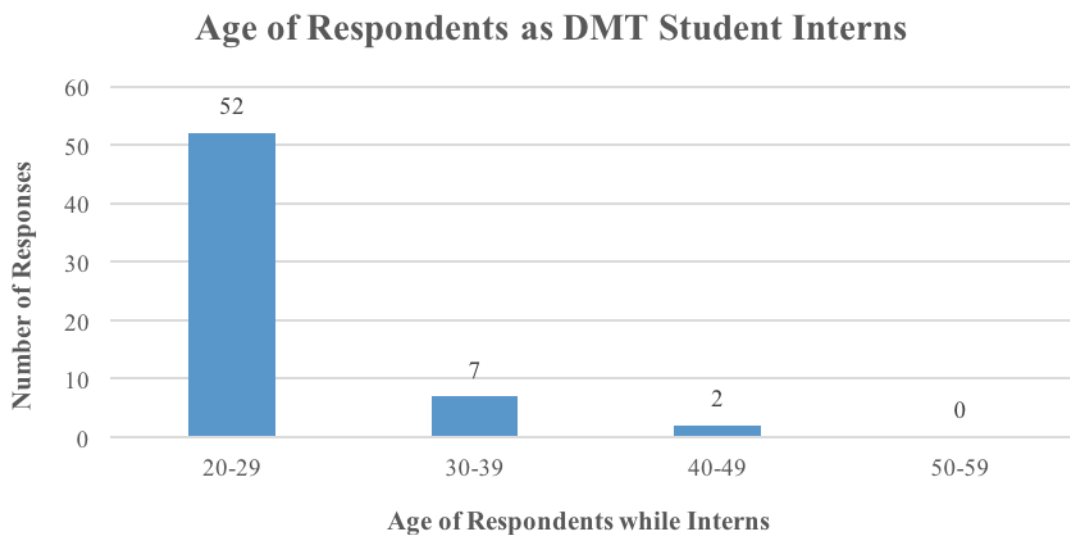


Figure 2. Age of respondents when DMT student interns at CCC.

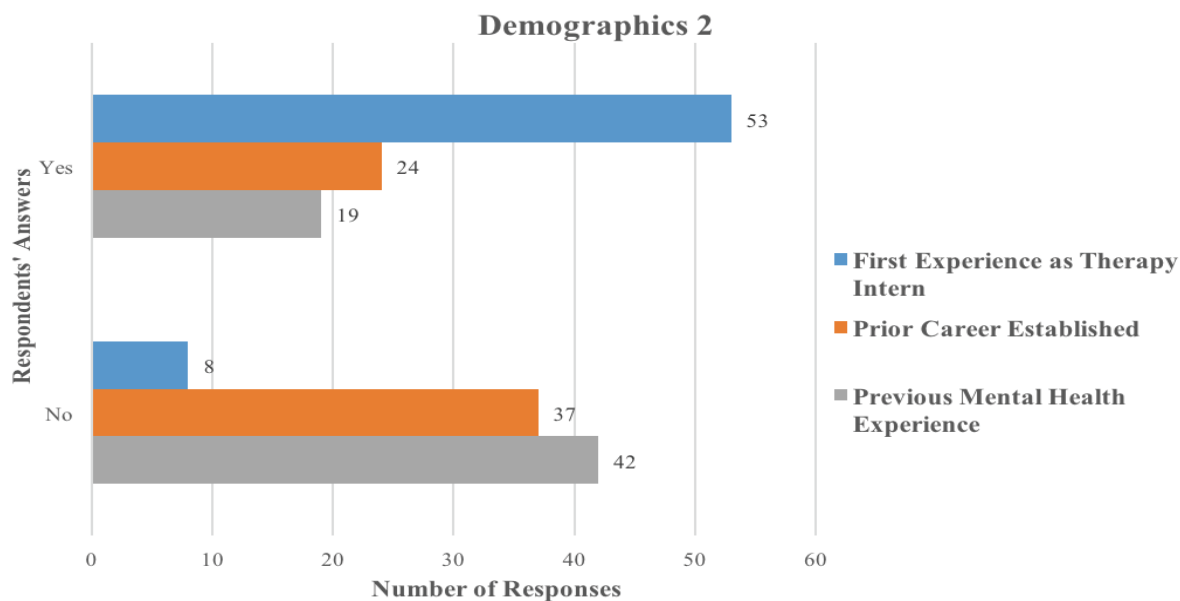
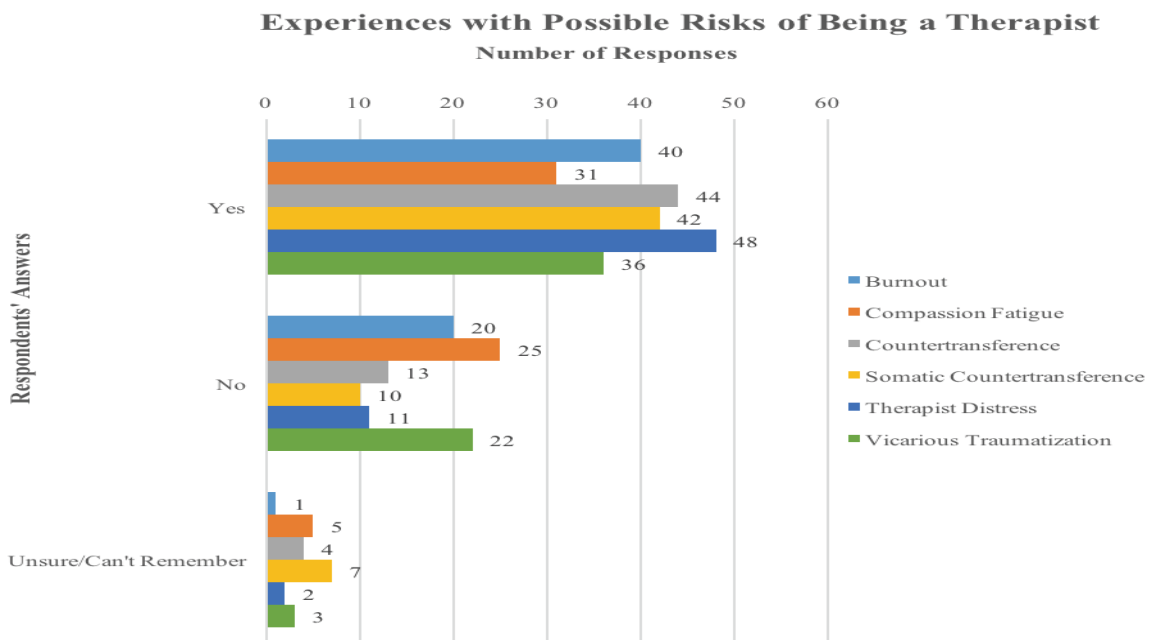


Figure 3. Comparison of respondents' answers to questions of first time experience as therapy intern, whether or not they had a previous career established, and their previous experience with mental health.

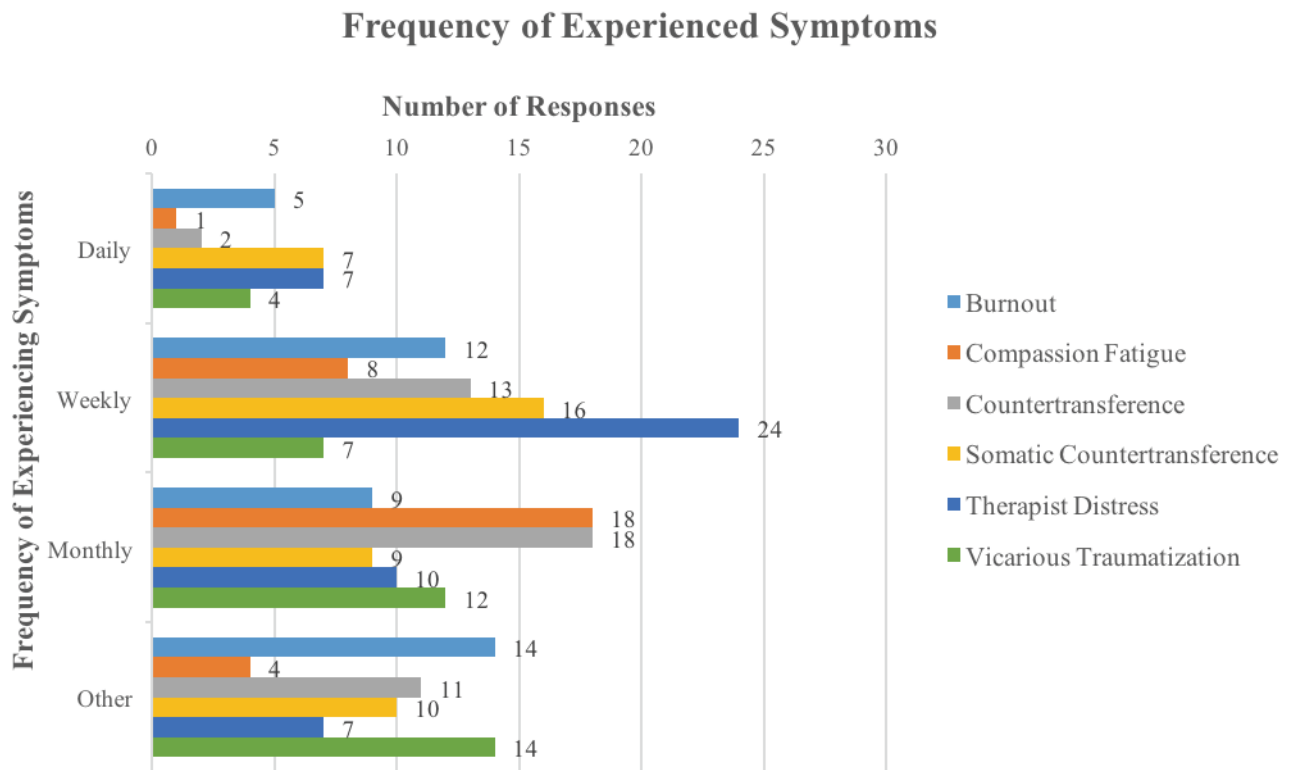
**Experiences with the risks of being a therapist.** Ninety-eight percent of respondents reported experiencing at least one risk of being a therapist (see Figure 4 below). These findings aligned with self-care and professional development literature, which has found interns and new professionals to experience the risks of being a therapist at higher rates than established professionals. These findings also supported one assumption that inspired this thesis project. It was assumed that most DMT student interns from CCC would experience at least one of the possible risks of being a therapist, if not more than one.

The majority of survey respondents reported experiencing at least one of the risks of being a therapist at some point in their practicum or internship experience. Therapist distress was experienced by 79% of respondents, countertransference was experienced by 72%, somatic countertransference was experienced by 71%, burnout was experienced by 66%, vicarious traumatization was experienced by 59%, and compassion fatigue was experienced by 51%.



*Figure 4.* Comparison of respondents' experiences with the possible risks of being a therapist while DMT student interns.

How frequently respondents experienced symptoms of the risks of being a therapist varied (see Figure 5 below). Most respondents experienced the symptoms of their reported risk of being a therapist on a weekly or monthly basis. However, several respondents also reported the frequency as “Other,” which included irregularly experiencing symptoms, experiencing the symptoms under specific circumstances, or being unable to remember frequency.

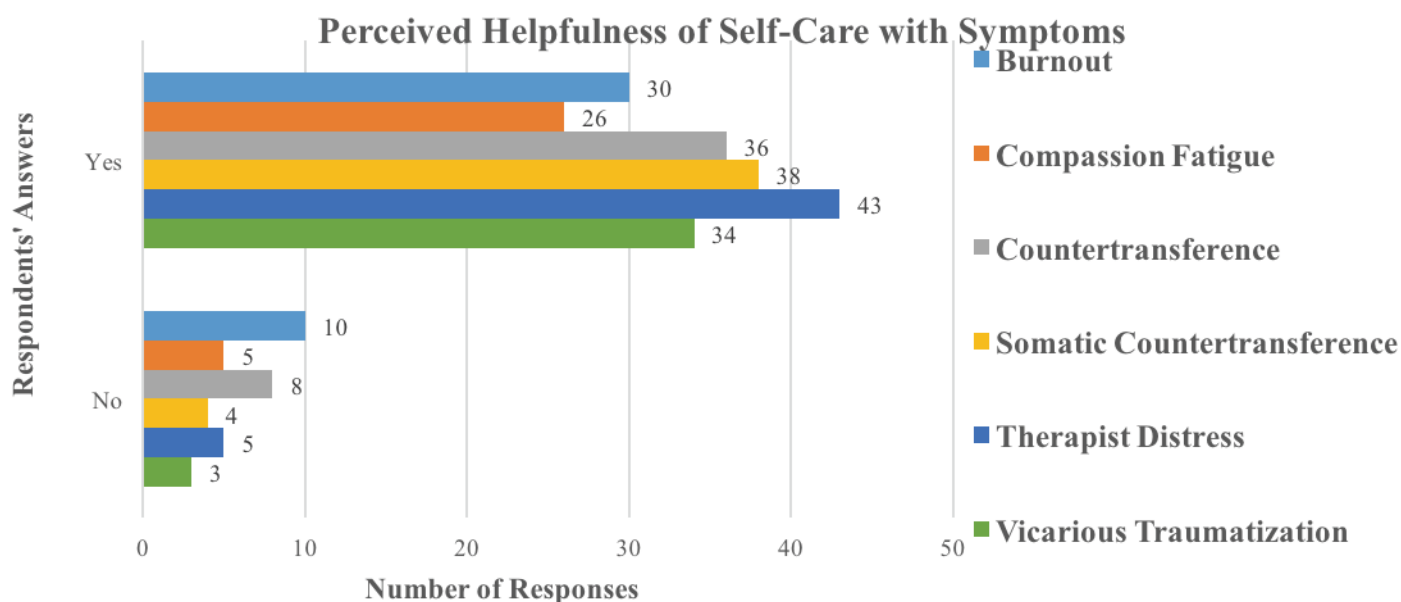


*Figure 5.* Comparison of how frequently symptoms of the risks of being a therapist were experienced by DMT student interns at CCC.

**Self-care practices of DMT student interns.** Along with asking about respondents’ experiences with the possible risks of being a therapist as DMT student interns, I also asked about their self-care practices as interns. I was curious about what types of activities they used, which was summarized with the content-analytic summary table. However, I was also interested in other aspects of respondents’ self-care practices as interns. When a respondent reported

experiencing a possible risk of being a therapist, the respondent was also asked if using self-care helped them cope with symptoms they experienced, what self-care activities they excluded from their practice, and how effective they rated their self-care practice when coping with a possible risk of being a therapist.

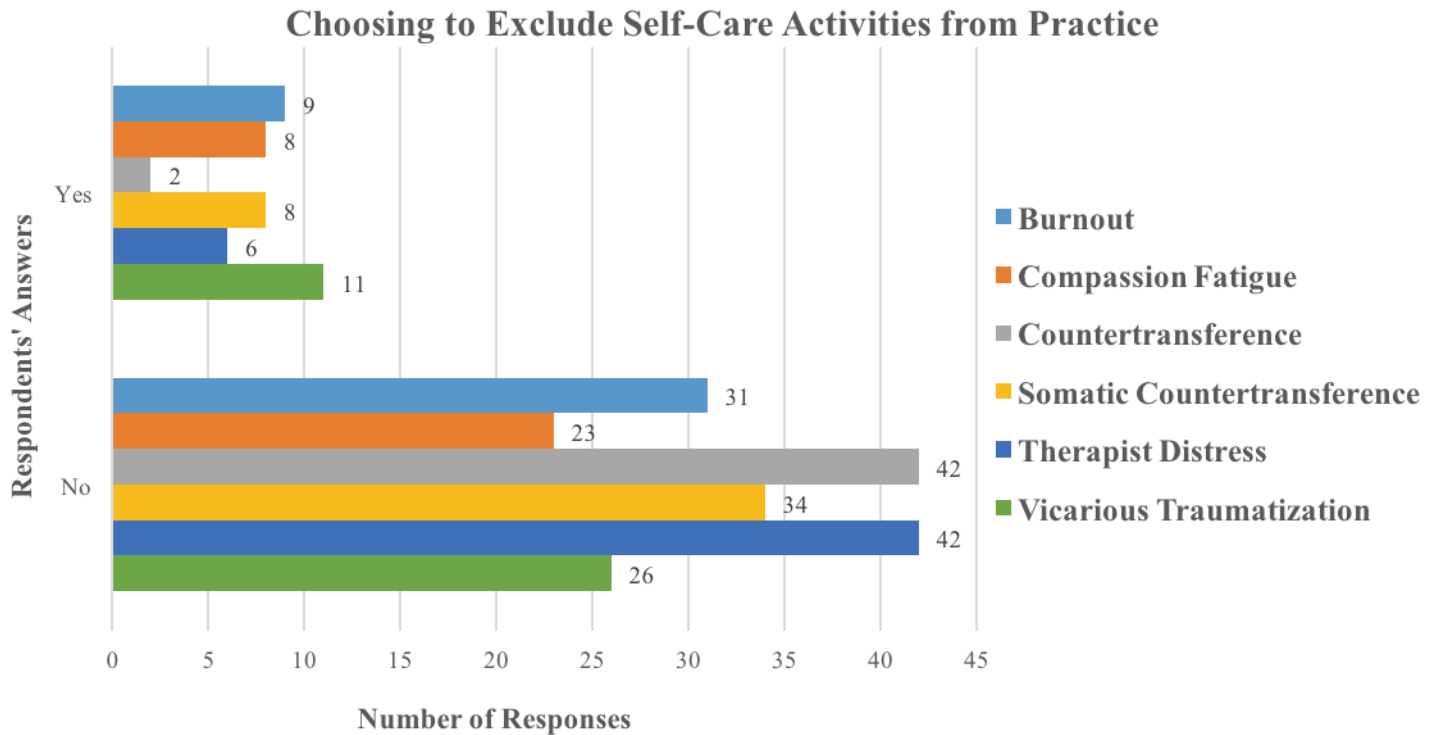
For each of the possible risks of being a therapist, 75% or more of respondents experiencing symptoms reported that self-care helped them cope (see Figure 6 below). Respondents were asked to provide what specific self-care activities were helpful for each risk (see Appendix E).



*Figure 6.* Comparison of whether or not self-care was perceived to be helpful when coping with symptoms of the possible risks of being a therapist.

Developing an effective self-care practice is an ever-changing process, however, so I was also curious to know if certain self-care activities were excluded and the reason(s) why (see Figure 7 below). The majority of respondents did not report excluding specific self-care activities, but there were a few activities repeatedly mentioned as being excluded. These activities were categorized as social support (e.g. isolating oneself, avoiding social interactions),

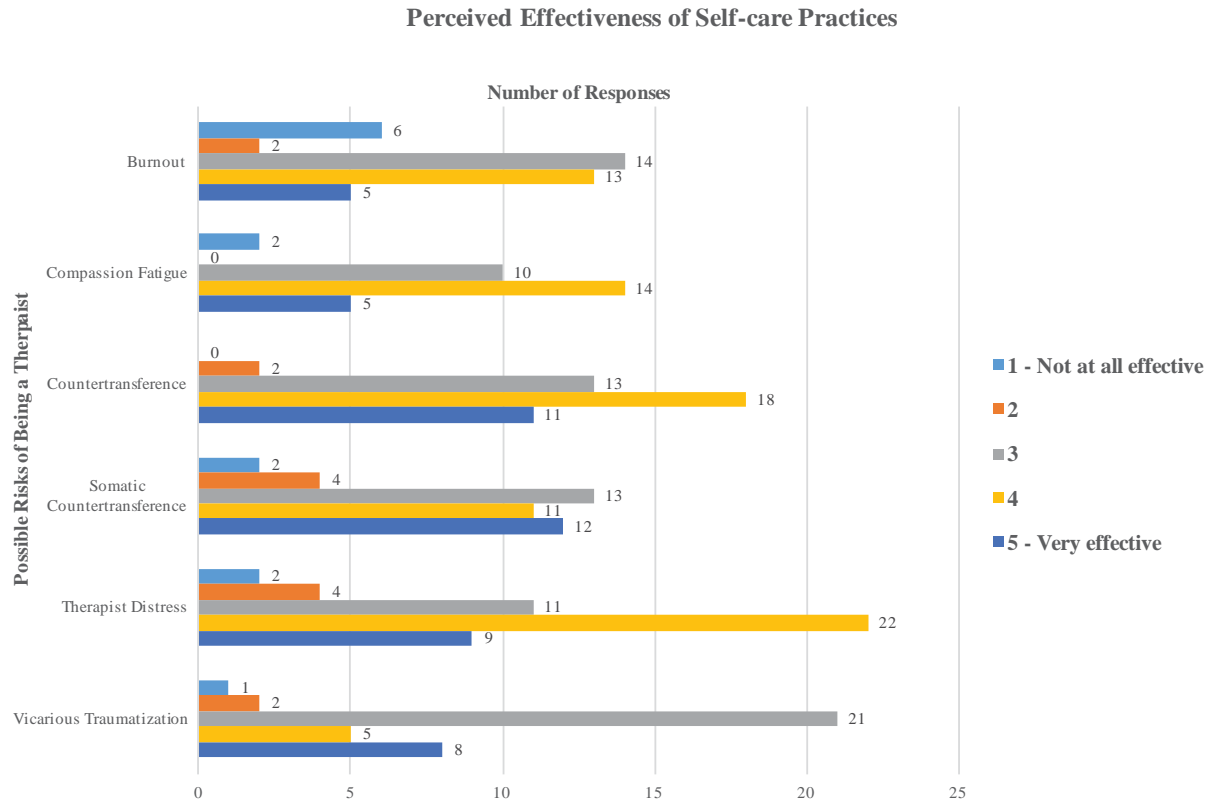
active activities (e.g. exercising), creative activities (e.g. dancing), health-related activities (e.g. attending appointments with chiropractor), and enjoyable activities (e.g. recreational reading, shopping). The respondents' reasons why these self-care activities were excluded will be examined further in the discussion chapter of this thesis.



*Figure 7.* Comparison of whether respondents chose to exclude specific self-care activities from self-care practice.

Respondents were also asked to rate how effective they perceived their self-care practice on a Likert scale with a range from 1-5 (see Figure 8 below). Fifty-five percent of respondents rated their self-care practices as effective or very effective (4 or 5 on Likert scale), 34% of respondents rated their self-care practice neutrally (3 on Likert scale), and 11% of respondents rated their self-care practice as ineffective or not at all effective (1 or 2 on Likert scale).



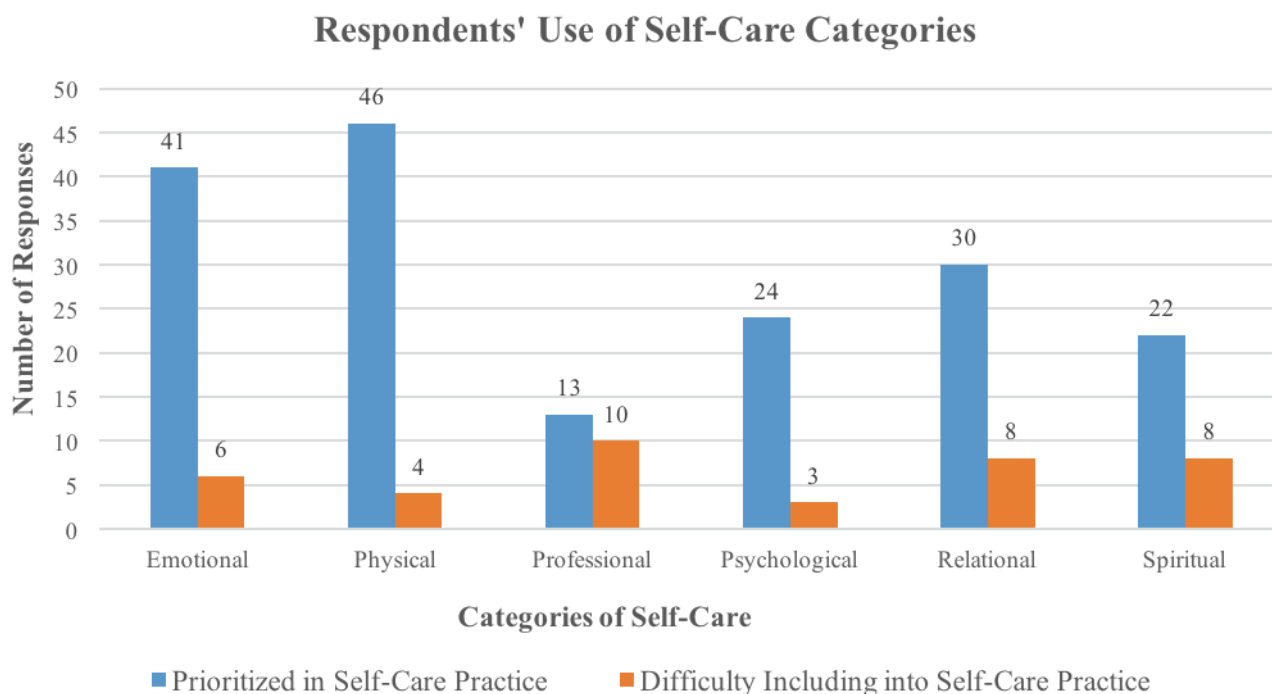


*Figure 8.* Comparison of the perceived effectiveness of respondents’ self-care practices when experiencing different risks of being a therapist.

A major focus of this thesis was to create products that were multifaceted and holistic in their approach to self-care. Respondents were asked to report which categories of self-care they tended to prioritize in their individual practices and which categories of self-care they found difficult to include (see Figure 9 below). Additionally, respondents provided reasons why they found certain categories difficult to include, which will be explored further in the discussion chapter.

Physical, emotional, and relational were the three categories of self-care reported as a priority by the majority of respondents. Professional, relational, and spiritual were stated as the most difficult categories to include in self-care practices. Many respondents cited the reasons

why they had difficulty including certain categories of self-care. The reasons that categories were difficult to include were a lack of resources to practice self-care (e.g. time, money, energy), unsupportive relationships, use of ineffective self-care, emotional barriers, and the need for exploration.



*Figure 9.* Comparison of how respondents prioritized or had difficulty incorporating self-care categories into their practices.

One of the final questions of this thesis asked respondents to rate the importance of developing a self-care practice while in graduate school (see Figure 10 below). The review of literature reiterated that many authors believed it important to develop a self-care practice early in a therapist's career, preferably while pursuing graduate training (Baker, 2003; Turner et al., 2005; Weiss, 2004). It was a base assumption of this thesis project, but I wanted to confirm this perspective with the survey respondents.

As I expected, the majority of survey respondents agreed. Ninety-three percent of respondents rated it as important or very important (4 or 5 on Likert scale), 5% of respondents rated neutrally (3 on Likert scale), and 2% of respondents rated it as not at all important or not very important (1 or 2 on Likert scale).

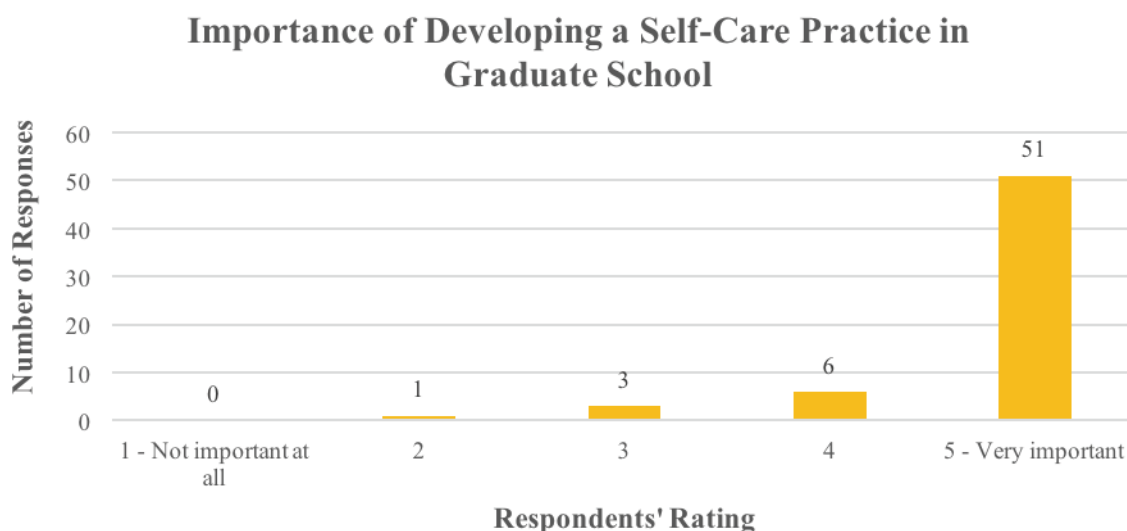


Figure 10. Respondents' ratings of the importance of developing a self-care practice in graduate school.

## Products

Determining the format of the two products was influenced by the survey respondents. When asked what type of resource would have been most helpful as a DMT student intern developing a self-care practice, 85% of respondents stated a booklet and 56% of respondents stated a website would have helped.

The booklet, *Self-Care for Dance/Movement Therapy Interns*, was created as a workbook so DMT students have a guided process when creating their self-care practice. The workbook could also be recommended as a curriculum resource at CCC for future students. A physical copy of the booklet is available in the DMTC program at CCC. An electronic copy of the booklet

is available with this thesis. The booklet includes an introduction to self-care as part of an individual's lifestyle and provides assessments to determine their self-care needs. The booklet also provides examples of self-care activities and researched benefits of these activities.

The website is an electronic resource for DMT student interns curious about their self-care practice and is found at [www.dmtselfcare.com](http://www.dmtselfcare.com). The information on the website provides a general overview of topics covered in this thesis along with suggestions of self-care activities, recommended self-care resources from survey respondents, and a blog. The blog will be updated regularly with self-care events in the Chicago area, reviews of books on self-care, and discussions on how to cope with obstacles to self-care (e.g. restricted time, limited finances).

The findings from this project were presented through the formation of themes and subthemes, numerical and visual graphs, and two products. These findings indicate the possibility of further exploration into the self-care habits of DMT student interns, experiences with the risks of being a therapist, and the creation of resources for dance/movement therapists. The next chapter will discuss these findings in further detail and the implications of these findings. Recommendations for future research will be discussed at the end of the next chapter.

## **Chapter Five: Discussion**

The guiding questions for this project were: What self-care activities are most effective for DMT student interns at CCC? What would a multifaceted self-care tool look like for DMT student interns? What body-based self-care activities are most effective for DMT students at CCC? The external input gathered from survey responses informed the process of creating self-care products for DMT student interns at CCC. The findings presented in the previous chapter will be discussed further alongside relevant literature related to therapist professional development, possible risks of being a therapist, and therapist self-care. This chapter will also address the implications, limitations, considerations, and insights of this project.

Within this project, survey respondents were asked to describe their self-care practice and what specific self-care activities they used. The specific activities mentioned by survey respondents tended to align with recommendations from the relevant literature, but there were activities reported that may be considered counterproductive to the intention behind self-care. When reviewing the external input gathered, I did not exclude certain information based on my judgment of whether or not the self-care activity was negative. An example of self-care activities that could have been deemed negative included smoking, using alcohol, and eating sweets. One respondent stated, “I know, not all positive, but true.” Including these activities could be considered counterproductive, but I chose to refrain from passing judgment without having full context. Although not considered the best coping mechanism, smoking and drinking alcohol can benefit the user in certain ways. It is possible respondents who cited using alcohol or other substances were overly reliant on these to cope, but it is also possible respondents were using these substances responsibly. Similarly, some participants mentioned eating desserts as part of their self-care, which tends to go against nutritional recommendations for a healthy diet.

Realistically, no one will have the perfect self-care practice. Without being able to gain the full context of substance use or dietary habits, I included the activities to avoid bias. My project was focused on creating products to be used as a reference, and it is ultimately decided by the user of the product what is most effective for their self-care practice.

### **Physical Self-Care**

The use of physical self-care was reported most frequently by participants of this project, and an abundance of examples of physical self-care activities were found within literature and responses to the survey. Respondents mentioned caring for themselves physically by fulfilling their basic needs, using body/mind practices, attending to nutrition/substance use, and being physically active.

**Overemphasis on physical self-care.** Myers and Sweeney (2005) stated that caring for the physical Self is usually overemphasized and tends to overshadow other forms of self-care, specifically the use of exercise and nutrition. The findings of this project noted physical self-care to be the most frequently reported form of self-care, and respondents reported being most likely to prioritize it. The benefits of being physically active and maintaining a balanced diet are well-known, but there is more to caring for the body as well. Other aspects of physical self-care recommended by literature include making appointments for routine medical care, getting adequate amounts of quality sleep, and staying hydrated throughout the day (Baker, 2003; Bradley et al., 2013; Hirshkowitz et al., 2015; Lazarus, 2000; Richards et al., 2014; Thorpy, n.d.).

One possible explanation that physical self-care was overemphasized is that DMT is a body-based field. DMT emphasizes the use of the body, mind, and spirit connection, which could explain why many respondents were actively doing physical self-care. Maintaining awareness of

the body is encouraged as a therapeutic technique when working with clients and to support dance/movement therapists' personal well-being (Forester, 2007). The high frequency of physical self-care is not necessarily a negative finding, but as mentioned by Myers and Sweeney (2005), the physical Self appeared to dominate DMT student interns' self-care practices.

**Physical self-care challenges.** Some respondents felt physical self-care was difficult to include in their self-care practice, however, because they felt physically fatigued or lacked the motivation to be active. Respondents described their self-care practices becoming increasingly passive to recuperate, but noticing the passivity was not helpful to them. Rothschild (2006) stated that some people need more passivity to feel recuperative, while others require more activeness to recuperate. Finding the right balance is different from individual to individual, but could lead to a more effective self-care practice rather than over- or under-exerting for recuperation (Rothschild, 2006).

Whether the types of self-care activities are truly effective or not is difficult to interpret without context, but the majority of findings seem to indicate physical self-care activities focused on improving health and well-being. Emotional self-care was the second most frequently reported form of self-care, and will be explored further in the next section.

### **Emotional Self-Care**

Emotional self-care was the second category most frequently prioritized by respondents, and the second most frequently reported category as found in the content-analytic summary table. Many of the specific self-care activities from respondents aligned with recommendations from literature, and seemed to have a balance of active and passive recuperative activities. How respondents conducted emotional self-care was through the use of creative activities, leisure activities and expressing their emotions.

**Creative activities.** The use of creative activities has been found to assist in the processing of emotions related to working with clients, which can be helpful for emerging therapists unsure of how to articulate these emotions (Bradley et al., 2013). Creative activities facilitate the expression of emotions that can be difficult to verbalize or may be outside of the therapist's conscious awareness (Bradley et al.). When using creative activities as self-care, it is recommended for therapists to focus on the creative process rather than evaluating the finished product for quality (Bradley et al.). The process is personal and focused on gaining a deeper understanding and being able to safely express emotions.

**Leisure activities.** Different types of leisure activities have been found to be helpful, as they provide emerging therapists respite from work and cultivate happiness and resilience (Baker, 2003; Richards et al., 2014; Skovholt et al., 2001; Turner et al., 2005). Therapists need ways to cultivate and replenish their own happiness, and leisure activities can help therapists self-regulate and cope during periods of high stress or difficulty (Richards et al., 2014). Knowing how to self-regulate can also increase therapists' resiliency when coping with the risks of being a therapist or facing other hardships in their personal and/or professional lives (Richards et al., 2014). Having a stable work/life balance, and regularly incorporating leisure and/or creative activities into self-care, can help emerging therapists in many ways. However, expressing emotions safely is another necessary component of emotional self-care.

**Expressing emotions.** Internship is typically emerging therapists' first experience working with real clients. Processing the complex circumstances and needs of various clients can feel emotionally overwhelming, especially for a novice professional (Rønnestad & Skovholt, 2003). When confronted with potentially complex and overwhelming emotional demands, it is recommended to find healthy ways of acknowledging, processing, and expressing emotions



(McCann & Pearlman, 1990). Expressing emotions can be done with creative activities, as mentioned earlier, but many survey respondents also cited journaling as one method of expressing their emotions. Individuals need to explore the best methods of expressing emotions for themselves, because this is a highly individualized part of self-care.

**Emotional self-care challenges.** Survey respondents mentioned avoiding emotional self-care at times, because they did not want to be *in the work* or felt helpless and out of control. One difficulty of becoming a therapist is that it tends to increase self-awareness around unresolved issues from the therapist's past (Cushway, 1997). When confronting these issues from their personal lives, in addition to their clients' concerns, it creates high emotional demands (Baker, 2003; Weiss, 2004). Working with clients has the potential to tap into therapists' vulnerabilities, which may be known or unresolved (Baker, 2003). For some student interns, these arising vulnerabilities may feel overwhelming when coping with numerous other personal and professional stressors.

Learning when and how to most effectively express and process emotions is a much needed aspect of therapist self-care. Although avoiding emotional expression long-term can be detrimental, becoming emotionally hijacked is also not helpful (Siegel, 2012). Siegel (2012) created the term "window of tolerance" to describe how much emotional intensity a person is able to process without becoming dysregulated (p. 281). Finding ways to safely express emotions can help keep the window of tolerance intact, rather than resorting to defense mechanisms like suppression or management to avoid feeling emotions (Siegel, 2012). While interns are learning how to walk this fine line, social support from supervisors, peers, instructors, and a personal therapist can be informative and provide emotional support along the way (Cushway, 1997).

Learning to use emotional self-care, and all other forms of self-care, is important both within a therapist's personal life as well as professional life.

### **Professional Self-Care**

Professional self-care was considered by respondents to be the most difficult form of self-care to include in their practice. However, when reviewing the types of activities listed, it was found that professional self-care was the third most frequently cited category. Many of the professional self-care activities reported by survey respondents aligned with recommendations from literature, including the use of body/mind practices, altering their environment, adjusting expectations, engaging in other professional activities, utilizing interpersonal support on site, and managing time. This could be indicative of a limitation of this project, which will be discussed in-depth later, but it could also indicate that many respondents did not recognize certain activities as possible forms of professional self-care.

**Body/mind practices.** Many respondents mentioned the use of body/mind practices between sessions or as a ritual to begin/end their day on-site. The types of body/mind practices included breathwork, grounding, finding connectivity through Bartenieff Fundamentals, or creating their own rituals (e.g. energy clearing). These types of practices do not require large amounts of space or time, and can be as simple as taking a moment to notice one's breath. Noticing if one is breathing quickly and shallowly may result in intentionally deepening the breath, which has been found to decrease heart rate, reduce stress, and lower blood pressure (University of Minnesota, n.d.). Interns can also create body/mind rituals with intention and personal significance. One respondent described a ritual of washing their hands between sessions to provide an opportunity to slow down between facilitating therapy groups. These types of practices are focused on increasing awareness of both the body and mind, so the intern can

mindfully work with clients rather than feeling hijacked or disconnected (Forester, 2007; Melius, 2013; Munnell Trif, 2010; Siegel, 2012).

**Professional environment.** Environmental factors are another component for interns to consider, although the ability to make large-scale changes to an internship site may be limited. Respondents mentioned taking opportunities to leave their site during lunch breaks as one way to recuperate. Other respondents cited setting boundaries with work-related technology, such as not answering emails outside of designated work hours. Within the role as an intern, the types of changes made to the internship environment may be small, but even small changes have been found to positively impact mood and well-being (Cummins et al., 2007; Rothschild, 2006; Skovholt et al., 2001; Turner et al., 2005; Weiss, 2004). These changes could include making an office space more personable with photographs or affirmations or rearranging a room used for therapy sessions (e.g. arranging chairs in a different way, dimming the lights).

**Adjusting expectations.** Expectations will vary from site-to-site, but also from individual-to-individual. Rønnestad and Skovholt (2003) discussed how interns' expectations are often skewed and unrealistically high, which creates additional stress. When expectations are too high, a process of altering these expectations is likely to be necessary (Brooks et al., 2002; Lengerich, 2001; McCann & Pearlman, 1990; Osborn, 2004; Skovholt & Rønnestad, 2003; Weiss, 2004). These expectations may appear as interns feeling overly responsible for things outside of their control or uncontrolled perfectionism (Rønnestad & Skovholt, 2003). Supervision is a helpful time for interns and supervisors to discuss what expectations are realistic and how these expectations can shift over time (Rønnestad & Skovholt, 2003).

**Diversifying professional activities.** Taking opportunities to diversify professional activities has been used as a form of self-care. This diversity may be facilitating multiple forms

of therapy (individual, group, couples), working with a variety of populations, and making time for other professional activities (e.g. clinical documentation, research) (Baker, 2003; Norcross, 2000). One respondent described how clinical documentation provided a break from facilitating therapy sessions and allowed him/her to process what occurred in previous sessions. Finding other ways to be involved professionally can also benefit new therapists, such as participation in professional associations or acting as a mentor (Baker, 2003; Osborn, 2004; Skovholt et al., 2001; Weiss, 2004). By diversifying one's professional activities, it provides opportunities to hear new perspectives and avoids creating monotonous work routine (Baker, 2003; Norcross, 2000).

**Interpersonal support.** Interpersonal support within professional contexts is also important for interns, which includes adequate supervision and learning to set boundaries. The importance of supervision is well-documented throughout professional development and self-care literature (Baker, 2003; Cummins et al., 2007; Cushway, 1997; Diaconescu, 2015; Forester, 2007; Hughes, 2014; Kleespies & Dettner, 2000; Osborn, 2004; Rønnestad & Skovholt, 2003; Weiss, 2004). Supervision is one way for interns to process emotions and thoughts related to their work, monitor well-being, collaboratively problem-solve difficult cases, and receive feedback on their progress as a professional. Supervision helps interns to feel connected to others at their site as well, including supervisors, colleagues, other staff members, and their graduate student peers. Borders described a good supervisor as being “empathic, genuine, open, and flexible” (1994, Characteristics of Supervisors, para. 1). Additionally, supervisors will have experience within the counseling field as a clinician, but can also take on the roles of teacher and consultant (Borders, 1994). Being able to use and shift between these three roles helps provide student interns with much needed adequate supervision during their training experience.

Learning to establish and maintain boundaries is an important aspect of professional self-care, and may feel difficult for new professionals without much previous experience (Baker, 2003). Creating therapeutic relationships that allow for presence and authenticity are essential, but also require a healthy degree of separation to avoid taking clients home or feeling overly responsible for their progress (Baker, 2003; McCann & Pearlman, 1990; Osborn, 2004; Turner et al., 2005; Weiss, 2004). Interns may struggle with boundaries, either being too flexible or rigid as they are learning. Skovholt and Rønnestad (2003) describe the ideal as “functional closure” (p. 49). This process involves being able to attune and attend to the information obtained from the therapeutic relationship without it overwhelming the therapist (Skovholt & Rønnestad, 2003). Survey respondents mentioned creating personal rituals to reinforce their awareness of boundaries called “energetic boundary setting” and “spatial boundary setting.”

**Managing time.** Time management was an additional form of professional self-care that several respondents cited. Depending on the site, there may be some limitations when it comes to time management as an intern. Literature and respondents recommend taking regular breaks throughout the day, taking time off (when possible), scheduling time to eat and avoiding a working lunch, and arriving early to prepare for the day ahead (Blazek, 2010; Lengerich, 2001). Effective time management has been found to reduce stress, so it is recommended for interns to explore various time management methods to find what works for them (Davis et al., 2000; Lazarus, 2000; Munnell Trif, 2010; Osborn, 2004).

**Professional self-care challenges.** As student interns take a step into the professional world, they tend to be more vulnerable to the possible risks of being a therapist (Rønnestad & Skovholt, 2003; Turner et al., 2005). This is why literature recommends to include education around self-care during the graduate training process, so there is an opportunity to begin building

a self-care practice sooner rather than later (Baker, 2003; Copeland, 2013; Turner et al., 2005; Weiss, 2004). Learning to develop a personal self-care practice may feel easier to student interns, whereas developing a professional self-care practice may feel more difficult due to the limitations of being an intern.

When reviewing the literature, there were several recommendations for professional self-care activities, but some of the sources appear more directed at paid professionals rather than student interns. There is encouragement to find sites that have self-care philosophies that align with the individual's values, diversifying professional activities, and adjusting/delegating your caseload (Chapman, 2013; Lengerich, 2001; McCann & Pearlman, 1990; Munnell Trif, 2010; Norcross, 2000; Osborn, 2004; Skovholt et al., 2001; Weiss, 2004).

These are great recommendations for self-care, but may not be completely realistic for a student intern. Partially, because there is a lack of control over certain factors (e.g. aligning personal self-care beliefs with internship site), but there also tends to be hesitancy for student interns to communicate these needs. Interns tend to rely on external validation, which may lead to reluctance to acknowledge or discuss their struggles (Rønnestad & Skovholt, 2003). This hesitation may be further amplified depending on the intern's personality or past experiences with acknowledging difficulty and asking for help (Baker, 2003; Brooks et al., 2002; Copeland, 2013; Munnell Trif, 2010).

An additional factor of difficulty and stress for some DMT student interns in CCC's program is balancing the role of clinician and researcher. Student interns already have to balance their academic and clinical roles, as they are a student being graded on their work while learning to apply the knowledge learned in a classroom with real clients. However, the additional pressure of conducting research at their internship site adds further expectations and concerns to be

juggled (Turner et al., 2005). Balancing the role of researcher and its requirements may be difficult for student interns, as they are still exploring the new role of clinician. Additionally, student interns may feel pressure for their research to demonstrate positive results, which may be disruptive for the therapeutic relationship. If students are consciously or subconsciously seeking specific results, they may not be authentically present in the therapeutic relationship. This is not to say it is not possible to manage the role of researcher and clinician, but it may require additional attention from supervisors, faculty, and the student interns to maintain awareness of when the roles interfere with one another.

### **Relational Self-Care**

Respondents had an interesting connection to relational self-care, as it was reported as being the third most prioritized form of self-care and also the second most difficult form to include into a self-care practice. When reviewing the specific self-care activities cited by respondents, types of relational self-care were the fourth most frequently reported activities within the content-analytic summary table. The activities were organized into the subthemes: relation to self, sex, and social support.

**Relation to self.** Developing and maintaining a positive relationship with Self is encouraged for emerging therapists (Baker, 2003; Copeland, 2013; Richards et al., 2014; Sapienza & Bugental, 2000). Copeland (2013) wrote about learning to develop self-compassion and how it impacted her experience as a DMT intern and her self-care practice. Copeland (2013) found that the use of self-compassion helped her practice self-care with intention, rather than adopting a perfunctory self-care practice that did not address her needs. Self-compassion is a way to connect and care for the self without judgment or criticism (Neff, n.d.). Student interns

who approach self-care in this way are encouraged to accept their humanness and treat themselves with the same kindness extended to others (Neff, n.d.).

Another component of improving relationship to Self includes committing to a lifelong self-care journey (Baker, 2003; Osborn, 2004). Setting this intention is a helpful reminder that a self-care practice will change over time as an individual goes through personal and professional life transitions. However, it is also an opportunity to make a direct commitment to caring for the Self. Establishing a balance between caring for Self and caring for others can feel difficult for some emerging therapists. It can feel especially fulfilling and selfless to help others, but selfish to dedicate time and energy to caring for oneself (Baker, 2003; Skovholt et al., 2001). Women tend to have the expectation of selflessness as part of their society and culture, which can result in female therapists having greater difficulty in finding this balance (Sulik, 2007). DMT as a field is predominantly female; the ADTA estimates 98.9% of its current membership is female, which means a large majority of new dance/movement therapists may grapple with this conflict (Y. Hynson, personal communication, October, 25, 2016).

**Sex.** Sex, with oneself or partner(s), was considered by Maslow to be a basic need (McLeod, 2007). When reviewing the literature around self-care, sex was a topic rarely included or discussed by sources despite its known benefits. Engaging in masturbation and/or sex with another person has been found to have numerous benefits, such as lowering blood pressure, reducing risk of heart disease, reducing stress, and enhancing sense of overall well-being (Brody, 2006; Grewen, Anderson, Girdler, & Light, 2003; Lindau et al., 2007; Rerkpattanapipat, Stanek, & Kotler, 2001). Only two respondents mentioned sex as part of their self-care practice, and did not distinguish whether it was sex with and/or without a partner. One possible recommendation for future therapist self-care resources is to discuss and encourage the exploration of one's



sexuality. Rather than avoiding the topic, it could be helpful for future DMT student interns to recognize that sexuality is a basic need and an important part of relational self-care.

**Social support.** The importance of having social support is well-documented within self-care literature (Baker, 2003; Blazek, 2010; Brooks et al., 2002; Chapman, 2013; Cushway, 1997; Diaconescu, 2015; Figley, 2002; Lengerich, 2001; Sapienza & Bugental, 2000; Skovholt et al., 2001; Turner et al., 2005). One of the most common types of self-care mentioned by respondents related to social support. Different types of social support can include family members, friends, peers, significant others, colleagues, and instructors. Spending time with other people may tap into other forms of self-care, such as professional or emotional self-care. As an example, if a person attends a comedy show with a friend, this may act as a form of relational self-care and emotional self-care.

The dynamics of a relationship are also essential to consider when it comes to social support. This includes, but is not limited to, forming healthy boundaries with others and having reciprocity within relationships (Baker, 2003; McCann & Pearlman, 1990; Osborn, 2004; Richards et al., 2014; Turner et al., 2005; Weiss, 2004). Relationships that are one-sided or potentially abusive are not considered self-care (Richards et al., 2014).

**Relational self-care challenges.** Respondents mentioned having difficulty with relational self-care for various reasons. Some respondents reported the desire to isolate when experiencing symptoms of possible risks of being a therapist, which Munnell Trif (2010) experienced as a DMT student intern coping with burnout and vicarious traumatization. When recounting her experience as an intern, Munnell Trif (2010) specifically states she had “less-than-healthy tendencies towards independence and capability,” which led to isolation as a way to prove her worth to the site (p. 43). Munnell Trif’s experience relates to the stage of professional

development of the advanced student, which involves the desire to fulfill others' expectations while relying on external feedback to validate their progress (Rønnestad & Skovholt, 2003). This pressure to meet expectations may manifest differently, depending on the intern's personality, and isolation was mentioned by respondents as one manifestation. Other reasons relational self-care was not prioritized by respondents included feeling misunderstood by their social support and desiring more time alone. The desire to separate from others is not inherently negative, and can be beneficial for therapists who are consistently working in relationship to others. Rather than deeming time alone as something to avoid, student interns can be aware of when their isolation is a possible symptom or part of their self-care.

### **Spiritual Self-Care**

When asked about spiritual self-care, respondents reported having difficulty including spiritual self-care into their practices. A similar finding was outlined in the content-analytic summary table; as spiritual self-care activities were only mentioned 106 times. When looking at the spiritual self-care activities, the subthemes that emerged were: the use of spiritual activities and seeking spiritual support.

**Spiritual activities.** Respondents cited using different types of activities to connect to their spirituality, such as yoga, meditation, prayer, and being in nature. Within the literature, there is a distinction made between religiosity and spirituality. Spirituality revolves around the experience of transcendence and connection to something larger than oneself (Rothwell, 2006). What a person is connected to will vary from individual to individual, for some individuals they may connect to a specific religion's god and others may feel connected to nature. Certain activities may help to activate this connection, such as prayer or meditation, and this provides one avenue to engage in spiritual self-care.

**Spiritual support.** Seeking spiritual support was mentioned by several respondents, but there was no elaboration on what this looked like for different individuals. For some respondents, this could have involved attending religious services or groups with similar beliefs to their own (Blazek, 2010). Expanding the topic on where to find spiritual support and how to explore spirituality could be beneficial to DMT student interns. Rothwell (2006) had recommendations for students to explore spirituality, which included learning about various philosophies or theories, embodying spirituality through movement or rituals, and making adjustments to the physical environment (e.g. use of incense, candles). Even though there is interest in embracing spirituality more actively as part of self-care, many respondents still cited uncertainty about ways to explore their spirituality.

**Spiritual self-care challenges.** Connecting to spirituality is not a new challenge for new therapists as it was once shrouded with stigma (Behere et al., 2013; Rothwell, 2006). The discussion around a therapist's spirituality became increasingly complex (Rothwell). Therapists questioned how their spirituality may affect the therapeutic relationship and the appropriateness of spiritual techniques within certain clinical settings (Rothwell). Despite concerns, Rothwell wrote about various creative arts therapists who incorporated or explored spirituality in their work with clients. Although some dance/movement therapists associate the body/mind/spirit connection with the field of DMT, there appears to be a gap in truly connecting to spirituality in their work with clients or their self-care practice (Rothwell). One recommendation from Rothwell's research is to encourage training therapists to do more research into various spiritual and religious belief systems and to more openly speak about spirituality within graduate programs.

## **Psychological Self-Care**

Psychological self-care was considered by respondents to be the least difficult to include in their self-care practices. Yet, when looking at the number of self-care activities under psychological self-care in the content-analytic summary table, it was only mentioned 94 times by respondents. Possible reasons for the conflicting findings will be discussed later in this chapter. The subthemes found for this category included the use of body/mind practices, furthering education, simplifying, examining thought processes, and attending therapy.

**Incongruence in findings.** Reasons for the incongruence between the respondents' reports and the findings is unclear. Uncovering the reason, or reasons, why this incongruence occurred would require more inquiry and exploration beyond the scope of this project. However, I believe one reason the incongruence occurred is that respondents categorized certain self-care activities as psychological, which I may have organized differently during meaning-making processes. As an example, one respondent may have considered getting a massage to be psychological self-care as he/she finds it to be very relaxing, but I may have categorized this as physical self-care assuming the respondent was seeking to care for the body. This inability to member check, due to the nature of the survey, may have resulted in the findings being skewed. It is also likely that respondents did not list every self-care activity they have done, which makes it appear as if psychological self-care is performed less often.

**Body/mind practices.** The types of psychological self-care mentioned by respondents aligned with recommendations from the literature. Respondents cited examples of using body/mind practices as a way to relax and relieve stress, such as practicing mindfulness and progressive relaxation exercises (Baker, 2003; Chapman, 2013; Davis et al., 2000; Munnell Trif 2010; Richards et al., 2014; Rothwell, 2006; Sapienza & Bugental, 2000). Since the respondents

were DMT students, it is understandable that they would draw upon the body/mind/spirit connection when performing self-care as this is a major assumption within the field of DMT (ADTA, n.d.). These types of practices can result in psychological benefits, such as reduced stress, improved memory, and increased ability to focus (Davis & Hayes, 2012). Mindfulness and progressive relaxation exercises include the body, but the assumption was that the reason for doing these activities was to improve psychological well-being.

**Furthering education.** Furthering education or training, whether this is in relation to professional development or unrelated to a person's career, has been used as a form of self-care (Baker, 2003; Figley, 2002; Forester, 2007; Hughes, 2014; Lengerich, 2001). This can take the form of continuing education programs or seeking new degrees or certifications, which could be related to a career in therapy or an interest unrelated to work. However, further education could also relate to dedicating time to personal growth, as some respondents mentioned using self-help books and staying informed with current events. Another major recommendation within the literature was to increase the education on self-care within therapist training programs (Agor, 2003; Baker, 2003; Bradley et al., 2013; Chapman, 2013; Copeland, 2013). Instead of sidelining discussions around self-care for other topics, the literature recommends these discussions are consistent, in-depth, and presented early in graduate training programs.

**Simplifying.** The idea of simplifying was another form of psychological self-care found within literature that some respondents mentioned was part of their self-care practice. Simplifying could involve decluttering one's office or home space, such as cleaning or organizing (Richards et al., 2014; Weiss, 2004). Simplifying could also relate to decluttering one's schedule with a focus on time management (Davis et al., 2000; Lazarus, 2000; Munnell

Trif, 2010; Osborn, 2004). Simplifying, in whatever form, has been found to effectively reduce stress (Bourg Carter, 2012; Clear, 2014; Richards et al., 2014; Weiss, 2004).

**Thought processes.** A large part of psychological self-care involves thought processes, such as self-talk, defense mechanisms, and self-awareness. Respondents mentioned cognitive processes as part of psychological self-care, including using positive self-talk, engaging in self-reflection, compartmentalizing, and emphasizing optimism. These types of activities have been found to benefit emerging therapists, especially in early stages of professional development. The use of self-reflection and positive self-talk can help new professionals to develop an intrinsic source of motivation and appraisal, rather than relying solely on external sources for validation (Rønnestad & Skovholt, 2003).

Baker (2003) emphasizes increasing self-awareness and using self-reflection when doing self-care. It helps inform an individual of their needs, and encourages them to consistently reevaluate how their needs may change over time or context (Baker, 2003; Bradley et al., 2013). Other sources encourage examining thought processes to notice how they are helping or hindering therapists (Davis et al., 2000; Figley, 2002). Addressing thought processes can be done with approaches like cognitive-behavioral therapy, but this can also be done with other forms of therapy (Chapman, 2013; Copeland, 2013; Figley, 2002).

**Therapy.** Attending personal therapy is highly recommended for interns and new therapists (Baker, 2003; Blazek, 2010; Chapman, 2013; Copeland, 2013; Forester, 2007; Hughes, 2014; Kleespies & Dettner, 2000; Lengerich, 2001; Mahrer, 2000; Melius, 2013; Norcross, 2000; Osborn, 2004; Skovholt et al., 2001; Turner et al., 2005; Weiss, 2004). Therapy provides emerging therapists with the opportunity to examine how they are being affected by their work, but also to focus on their personal life as well. Therapists are people too, and may need to engage

in their own personal therapy to reduce their stress and increase overall well-being (American Psychological Association [APA], n.d.a). In addition to reporting about specific self-care activities, respondents also revealed relationships between the possible risks of being a therapist and categories of self-care.

### **Experiencing the Possible Risks of Being a Therapist**

Ninety-eight percent of respondents experienced at least one possible risk of being a therapist, and several experienced more than one during their internships. Therapist distress was the most frequently reported followed by countertransference, somatic countertransference, burnout, vicarious traumatization, and compassion fatigue. As mentioned earlier, experiencing the possible risks of being a therapist does not mean the therapist is incompetent (Kottler, 2010; McCann & Pearlman, 1990; Norcross, 2000). However, self-care is one way to diminish the intensity of the symptoms associated with the risks and possibly prevent future occurrences.

**Therapist distress.** Therapist distress being reported most frequently by respondents is understandable, as it describes therapists experiencing distress when coping with stressors from their professional and personal lives, as any other person does. The intensity of symptoms for therapist distress have a large range from being easily managed to overwhelming. As Baker (2003) said, therapist distress does not prevent therapists from continuing their work, but it cannot be ignored. Therapist distress may transition into therapist impairment if the symptoms are not addressed and self-care is not actively used (Baker, 2003; Bradley et al., 2013).

Experiencing therapist distress was not uncommon for survey respondents; 79% reported experiencing symptoms of therapist distress at some point in their internship. Completely eliminating the therapist distress from an intern's experience is impossible, but there are ways to prevent it from transforming into therapist impairment. Some recommendations included

improving the quality of supervision, increasing discussions about work/life balance, providing concrete recommendations for self-care, and improving the quality of the supervisor/supervisee relationship (Thompson, Frick, & Trice-Black, 2011). Survey respondents used all the categories of self-care to cope with therapist distress, but physical self-care activities were the most frequently reported. Countertransference also affected a majority of respondents, but there was a stronger preference to utilize professional self-care when experiencing symptoms.

**Countertransference.** When asked about countertransference, 72% of respondents reported experiencing it during their practicum and/or internship. Countertransference is regarded as a universal phenomenon for therapists, but has the potential to negatively affect therapists if it is not addressed (Figley, 2002; McCann & Pearlman, 1990). When used constructively, countertransference can be used to gain insight into clients' situations, or it may inform the therapist of the need to resolve past issues that may interfere with their work (Baker, 2003). Countertransference typically emerges from therapists' personal vulnerabilities and unresolved conflicts, which is triggered when working with certain clients (Baker, 2003). If countertransference is not further explored, however, it could negatively affect therapists. Survey respondents reported accessing all categories of self-care to cope with countertransference, but the most frequently used category was professional self-care, specifically the use of supervision. Although countertransference was an experienced risk for 72% of survey respondents, somatic countertransference was also a common experience for 71% of respondents.

**Somatic countertransference.** Countertransference was a widely recognized phenomenon for therapists, and over time somatic countertransference has gained similar recognition. Symptoms of somatic countertransference affect therapists' bodies and can range from sensations to full-blown sensory experiences (Forester, 2007; Rothschild, 2006). To



effectively address somatic countertransference, therapists are encouraged to utilize the body/mind connection and approach self-care holistically (Forester, 2007). Somatic countertransference can be another useful tool for therapists to gain insight into clients' experiences, similarly to countertransference. Survey respondents reported using a holistic approach when experiencing somatic countertransference and utilized all categories of self-care. Professional self-care activities were most frequently used by respondents experiencing somatic countertransference, specifically the use of various body/mind practices. For respondents experiencing burnout, however, physical self-care was used most frequently to cope.

**Burnout.** Burnout was experienced by 66% of survey respondents during their time as a DMT student intern. Young and/or inexperienced therapists tend to be more vulnerable to burnout (Baker, 2003; Turner et al., 2005), and burnout tends to manifest more intensely than other possible risks of being a therapist (Rothschild, 2006). If burnout is not addressed, it can result in declines in therapists' health, increased cynicism in their outlook on life, decreased quality of care, and the possible desire to change careers (Cummins et al., 2007; Richards et al., 2014; Rothschild, 2006).

When experiencing burnout, respondents utilized all categories of self-care, but physical self-care activities were the most frequently reported. Attending to basic needs and engaging in various forms of physical activity were the most common forms of self-care. One common symptom of burnout is exhaustion, which can manifest physically, psychologically, and emotionally (Baker, 2003; Cummins et al., 2007; Diaconescu, 2015; Figley, 2002; Maslach, 2003; Richards et al., 2014; Weiss, 2004). The cause of this exhaustion is complex, a combination of professional and personal reasons, which may explain why respondents focused on their basic needs. Rather than only focusing on one possible cause of burnout, it seems

respondents chose to focus on taking care of their basic needs and ensuring they were remaining physically active. Physical self-care was also a priority of respondents when experiencing vicarious traumatization.

**Vicarious traumatization.** When asked to report on their experiences with vicarious traumatization, 59% of respondents confirmed experiencing this risk of being a therapist. Since dance/movement therapists use the body/mind/spirit connection, it is understandable that there is an increased awareness and understanding when the body is being affected by a clients' material. Respondents appeared aware of not only how clients' material would affect them psychologically and emotionally, but also how it would manifest in the body.

To cope with this risk, respondents used all categories of self-care, but appeared to favor physical self-care. The types of physical self-care activities most frequently used by respondents to cope with vicarious traumatization were various physical activities and body-based practices. As discussed by Forester (2007) and Rothschild (2006), the body is intensely affected, and therapists' nervous systems relive clients' experiences with trauma during and beyond therapy sessions. It appears that many respondents chose to start to address their symptoms of vicarious traumatization by making physical self-care a priority, and one CCC alumni recommended this approach (Melius, 2013). Melius (2013) stated that using body-based experiences offers therapists ways to better understand the nonverbal aspects of vicarious traumatization and link it to verbalized understanding. The idea of meeting vicarious traumatization *where it's at*, on a body level, could then allow therapists to begin exploring what other forms of self-care would be helpful. The final risk of being a therapist experienced by respondents was compassion fatigue, and although it was the least frequently reported experience, it still affected more than half of respondents.

**Compassion fatigue.** When reviewing literature, I found it difficult to conceptualize and distinguish compassion fatigue from the other possible risks of being a therapist. There are several different definitions of compassion fatigue in the literature, and it is also a relatively new term for the older concepts of secondary traumatic stress or secondary traumatization (Bride et al., 2007; Figley, 2002). The vagueness of the term, and its possibility of overlapping with other potential risks of being a therapist, could have contributed to compassion fatigue being least frequently reported by survey respondents. However, this project relied upon respondents' self-reports, and assumes they attempted to report their experiences as accurately as possible.

Professional self-care activities were prioritized by respondents experiencing compassion fatigue. Interpersonal support within a professional context was the most cited self-care activity, specifically setting boundaries and attending supervision. Hughes (2014) stated that therapists over-identifying with clients and blurring boundaries increases the risk of developing compassion fatigue. It seems respondents might have been aware of this possible cause, or supervision increased their awareness, and prioritized boundary-setting to cope with the experienced symptoms of compassion fatigue. Supervision may have also provided respondents with an opportunity to identify what symptoms of compassion fatigue were being experienced and how to cope with the symptoms.

All the possible risks of being a therapist explored within this project affected more than half of survey respondents. The most frequently experienced risk was therapist distress affecting 79% of respondents and the least frequently experienced risk was compassion fatigue affecting 51% of respondents. The two categories of self-care that were prioritized by respondents when experiencing one or more risks of being a therapist were physical self-care and professional self-care. All categories were used when experiencing symptoms of the risks of being a therapist, but

respondents favored these two categories specifically. This project also considered how other factors may have affected respondents' experiences and self-care practices as DMT student interns, such as developmental and professional needs.

### **Further Comparisons to Literature**

**Ever-changing self-care needs.** People change over time as do their needs; this also applies to self-care needs. Baker (2003) discussed how self-care needs are influenced by each therapist's current stage of life personally and professionally. When trying to determine a therapist's self-care needs, it can be helpful to consider the developmental needs of the currently experienced stage of life and professional development needs associated with stages of career development (Baker, 2003; Rønnestad & Skovholt, 2003).

Survey respondents were asked to provide some information on their background, including age while a DMT intern, prior experience as a therapy intern, previous experience in the field of mental health, and whether or not they had a career prior to being a DMT intern. This information was used to provide more context regarding respondents' self-care practices and illuminated possibilities for some of the project's findings.

Eighty-five percent of respondents reported their ages to be 20-29 at the time of their internship and eighty-seven percent of respondents reported having their first experience as a therapy intern in the DMTC program as shown in Figures 1 and 2 of Chapter 4. Sixty-one percent of respondents did not have a career prior to their therapy intern experience and 69% had no previous experience in the mental health field (see Figure 2). The majority of students going through the program have been young adults entering into the role of therapist for the first time. When considering this information, finding that 98% of respondents experienced at least one (or more) possible risk of being a therapist is understandable (see Figure 3).

Novice professionals are more susceptible to the possible risks of being a therapist (Skovholt & Rønnestad, 2003; Turner et al., 2005). During young adulthood, there tends to be more ambiguity and uncertainty in multiple areas of an individual's life, including relationally, professionally, and financially (Baker, 2003; Cushway, 1997). Professional stressors are also present and earlier stages of therapist professional development tend to be filled with a combination of enthusiasm and anxiety (Baker, 2003; Rønnestad & Skovholt, 2003). By considering both the developmental stage and professional stage, there is an opportunity for insight into the needs of emerging therapists within these stages. However, young adulthood and new professionals are not the only ones with specific needs to consider.

Twelve percent of respondents reported being ages 30-39 during their time as a DMT student intern and 3% reported being ages 40-49 when DMT student interns (see Figure 1). Middle adulthood has its own stressors, including increased awareness of mortality and aging, balancing the responsibilities of multiple life roles (e.g. parent, supervisor), and grief and loss (Baker, 2003). However, Baker (2003) also discussed how individuals in midlife typically develop skills to help with self-regulation, and a shift to being internally focused and motivated when evaluating one's life personally and professionally. As with any developmental stage, there are challenges and advantages, and professional experiences are also a major factor.

Thirty-nine percent of respondents reported having a career established prior to their time as a DMT student intern and 31% of respondents had previous experience in the mental health field. The intersection between developmental needs and professional developmental needs can be complex as Baker (2003) described, "... therapists who enter the profession as a second career in midlife share the personal developmental needs of their age cohort but have the professional developmental needs of beginning practitioners" (p. 26). Other careers may have provided

opportunities to gain skills helpful for therapists, such as experience working on teams, improved communication skills, or practice with active listening. However, this does not necessarily mean that an individual with previous career experience will be in a later stage of professional development (Baker, 2003). As reflected in the gathered external input, 98% of DMT student interns from CCC experienced at least one potential risk of being a therapist – indicating the possibility of similar self-care needs for future DMT student interns regardless of age or prior career experience.

**Reasons self-care was not prioritized.** Reasons why respondents found it difficult to prioritize specific forms of self-care, or certain types of self-care activities, was addressed previously. Yet, many respondents mentioned a lack of resources as an obstacle to practicing self-care, including time and money. When it came to practicing self-care, some respondents felt the time commitment was too large for their schedule or did not feel there was time to set aside. Many students balance a variety of obligations and life roles, such as student, intern, friend, family member, and employee (Baker, 2003; Cushway, 1997). Finding time to practice self-care is difficult enough, and if the individual is unsure of what activities will be most effective, it can start to seem impossible. It also seems to be a common misconception among respondents that self-care requires large amounts of time.

One outcome of this project was creating products that provided concrete examples of self-care activities, to cut down on the time needed to research self-care, and also to reinforce that self-care does not always require a large time commitment. Rather than feeling obligated to dedicate two hours per day to yoga class, a person could look for activities with smaller time commitments. Other examples include committing to meditating for 10 minutes per day or setting aside five minutes between sessions with clients to practice vertical roll-downs through

the spine. Although DMT student interns may feel overly restricted by time, it is also an opportunity to learn how and when to prioritize the Self, even when surrounded by other responsibilities. As discussed in previous sections, this can be a difficult skill to learn and use, but is immensely beneficial for emerging therapists to begin developing the skill earlier in their career.

Money and financial concerns were other commonly reported obstacles for respondents practicing self-care. Similar to time, many respondents expressed feeling limited by their financial situation when it came to practicing self-care. Graduate students studying to be therapists have reported feeling pressure around finances (Cushway, 1997; Weiss, 2004). As the cost of education continues increasing, it places a larger burden on students to find ways to fund their education (The College Board, n.d.). Although self-care can be costly, depending on what activities are used in a self-care practice, there are options to make self-care more cost-efficient.

Licensed professional counselor Emily Roberts (2015) stated, “Self-care is simply the practice of treating yourself with enough respect that you honor and fulfill your own needs as they arise” (para. 1). Many different types of self-care activities are free or a low-cost option is available. If an individual loves reading as part of their self-care, but cannot afford to buy new books regularly, there are options. One option is to go to used bookstores to avoid paying full price for books, or the person could register with their local library and check-out books for free. In addition to feeling a limitation in resources, respondents also cited excluding certain activities to improve their overall self-care practice.

Some of the self-care activities excluded indicated respondents’ insight into whether or not these activities were truly helpful, or if activities were more likely to lead to negative, long-term consequences. Examples of these reasons included realizing the activities were ineffective

self-care (e.g. too much passivity) or the activities were creating negative long-term habits that were counterproductive (e.g. overindulging in desserts). Developing a self-care practice is an individualized process, which means there may be instances of trial-and-error along the way. Certain activities that were previously helpful may become ineffective, as a person's needs develop and change over time (Baker, 2003).

### **Limitations and Considerations**

**Self-report and limitation of recall.** One limitation of this project was that my survey depended on respondents to accurately recall past experiences and self-report. The choice to use a survey to gather external input meant the presence of self-report bias was more likely (Mertens, 2015). Self-report bias does not always mean intentional deception by survey respondents, but can also arise from respondents not knowing how to answer a question and/or being unaware that they lack this knowledge (Mertens, 2015). It is possible a respondent deliberately lied or exaggerated on certain questions, but respondents could have also skewed data because of uncertainty as well. Another consideration under self-reporting is the possible limitation in recall. The majority of respondents were alumni and asked about their experiences as a student intern. For some alumni, this experience was less than a year prior to the survey, but for other respondents this experience was more than 10 years ago.

**Possibility of response bias.** Another possibility within this project was response bias, as respondents' answers to survey questions may have been influenced by outside factors. Part of the sample that answered my survey included my own classmates, which means my relationship to these individuals could have influenced how they responded to the survey. Another possible factor is that the wording or phrasing of certain questions may have influenced how respondents answered. When designing the survey, the questions were created in a way to maintain as much



objectivity as possible, but this may not have eliminated all bias. The desire to be helpful to the project could have also skewed respondents to answer, consciously or subconsciously, in a way that was not entirely accurate to their experience.

**Possibility of researcher bias.** Another limitation is the possibility of researcher bias, specifically during the meaning-making processes. After being provided with external input, I reviewed the qualitative information and organized it into themes. Although I did my best to maintain objectivity throughout this process, it is possible that I subconsciously exposed the input to bias. It was not possible to validate my findings with respondents directly because of the survey's confidentiality, and this means researcher bias may have gone somewhat unchecked.

**Survey bias.** The design of the survey had its limitations and resulted in survey bias. Respondents may have been required to answer between 18 and 48 questions, which means some respondents may have been exposed to a lengthy survey. Some questions were skipped depending on whether or not respondents answered yes or no. An example of this type of question was: Did you ever experience any symptoms of compassion fatigue while an intern at Columbia College Chicago? If the respondent answered yes, the respondent was asked six follow-up questions to elaborate. However, if the respondent answered no, they were able to skip the follow-up questions. If respondents had to answer yes to several of these types of questions, this could have led to respondents experiencing survey fatigue. The length of the survey could have resulted in a decrease in quality of responses in terms of accuracy and detail, especially if a respondent became fatigued (Backor, Golde, & Nie, 2007).

Another concern with the design of the survey was ensuring the logistics of the survey worked correctly for all respondents. The example mentioned previously also demonstrates the survey's logistics. If the respondent provided a specific answer, they were either required to

answer more questions or allowed to skip ahead. This survey was tested multiple times prior to its electronic distribution, but an error in the survey logistics occurred which forced two respondents to skip a question that was meant to be mandatory. This survey logistics error is another limitation to this study as the information for two respondents was lost for the questions about somatic countertransference.

## **Conclusion and Future Research**

The purpose of this project was to create products to assist DMT student interns at CCC by creating a multifaceted self-care practice to cope with potential risks of being a therapist. Literature around the experience of novice professionals and possible risks of being a therapist were also reviewed. The findings from this project reinforced the need for these products as the majority of survey respondents reported experiencing the risks of being a therapist and expressed uncertainty with the process of creating a self-care practice as interns. Clarifying the definition of self-care and offering more concrete options within the products lays the foundation for future students interested in exploring self-care during their graduate training.

Another aim of the project was to use a holistic approach while exploring literature about therapist self-care and professional development, which informed the creation of the products. As dance/movement therapists, the Self is viewed as being comprised of multiple parts and all of them are interwoven through the body/mind/spirit connection. This idea of a multifaceted Self has been explored within self-care literature, such as The Indivisible Self model (Myers & Sweeney, 2005) and Maslow's Hierarchy of Needs (McLeod, 2007). I set an intention to create products that addressed all parts of the Self, including physical, emotional, psychological, relational, spiritual, and professional. This intention brought in suggestions for self-care activities

that were focused on nurturing specific parts of the Self, but also included self-care activities that nurtured multiple parts of Self.

The findings of this survey were gathered through qualitative and quantitative input. Meaning-making processes were then used with qualitative input to organize and create themes about respondents' self-care practices. This helped to highlight specific areas of self-care that may need to be prioritized and discussed further for future DMT student interns, such as spiritual and professional self-care. The findings also indicated what areas of self-care DMT student interns were utilizing frequently, and what specific activities have been found helpful for a self-care practice.

Quantitative input illuminated the experience of DMT student interns in CCC's program with the possible risks of being a therapist and self-care. 98% of surveyed respondents were found to have experienced one or more possible risks of being a therapist. The perceived effectiveness of respondents' self-care practices when experiencing these risks tended to be rated as neutral or effective, but few respondents considered their practices to be very effective. To address this concern, the products drew from literature and respondents' experiences to emphasize self-care options that would be more effective for DMT student interns.

**Future research.** This project illuminated possibilities for future research to explore further. The findings of this project could be used to begin tracking DMT student interns' experiences longitudinally with the possible risks of being a therapist and self-care. Focusing future research on tracking this information and uncovering patterns could increase understanding of the relationships between certain variables (e.g. experience with burnout and a student's developmental stage) over time. By observing these trends within CCC's DMTC program, there is a possibility of creating changes within the curriculum to enhance student well-

being throughout the duration of the program. Faculty and students could be made aware of what factors increase the likelihood of experiencing a possible risk of being a therapist and what types of self-care are most effective in preventing and/or coping with symptoms.

Future research could also be conducted on a larger scale beyond CCC's program to determine whether or not these findings would be generalizable and exploring the different experiences of DMT student interns between various graduate programs. This project focused on one program and its students' experiences, but future research could begin expanding the scope to more programs. Expanding research on dance/movement therapists' self-care could improve practitioners' quality of self-care and improve overall well-being personally and professionally. Research on dance/movement therapist professional development would also be helpful to illuminate what specific challenges students face when entering the field of DMT and what would be helpful to them as emerging clinicians.

Another option for future research would be doing a post-launch review of the products to track if they have been effective or ineffective. These products could be made available to future DMT students at CCC, within curriculum or as optional resources, to determine if the products are truly helpful or not. The results of this research could be used to further revise the products and enhance their effectiveness for DMT student interns. This review of the products could also indicate the need for a different type of product, such as a film or series of self-care workshops made available for students.

The need for self-care research is ongoing, especially for new therapists. The field of DMT is unique from other forms of therapy and could benefit from a specific focus on professional development and self-care needs for emerging dance/movement therapists. In addition to smaller scale studies and self-studies around these topics, larger scale studies on these

topics could inform and create a solid foundation that is less subjective and based on individual, unique experiences. Learning more about collective experiences could help to create literature and products relevant to the broad range of helping professionals.

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## **Appendix A**

### **Definition of Terms**

#### **Burnout**

“Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do ‘people work’ of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems... what is unique about burnout is that the stress arises from the social interaction between helper and recipient” (Maslach, 2003, p. 2).

#### **Compassion Fatigue**

“...reduces our capacity or our interest in bearing the suffering of others” (Figley, 2002, p. 1434); “Compassion fatigue breaks into two parts. The first part concerns things such like exhaustion, frustration, anger and depression typical of burnout. Secondary Traumatic Stress is a negative feeling driven by fear and work-related trauma” (Stamm, 2010, p. 8).

#### **Countertransference**

“Countertransference is from psychodynamic therapy and an emotional reaction to a client by the therapist irrespective of empathy, the trauma, or suffering. It is defined as the process of seeing oneself in the client, of over identifying with the client, or of meeting needs through the client... is chronic attachment associated with family of origin relationships and has much less to do with empathy toward the client that causes trauma” (Figley, 2002, p. 1435-1436).

#### **Empathy**

“Empathy allows us to relate to those in our care, to have a sense of what they are feeling. It also helps us put their experiences into perspective, understanding how they are being affected by the incidents that we are trying to mediate. When we have an insight, an accurate hunch, or seem to



read the client's mind, that may also be a result of empathy. Without it, we could not be the effective therapists that we are. Empathy is an integral, necessary tool of our work" (Rothschild, 2006, p. 10).

### **Impairment**

"Counselor impairment is a condition that compromises and reduces the quality of counseling received by clients. The causes of impairment may be due to a physical or mental condition or stress associated with situational factors" (Sheffield, 1998, p. 97).

### **Kinesthetic Empathy**

"As a therapist's feelings and thoughts react, respond, and engage with those of their patient, so does their body. This is kinesthetic empathy or mimesis" (Forester, 2007, p. 124).

### **Primary Traumatization**

"...the impact of a traumatic incident on the obvious victim of the incident" (Rothschild, 2006, p. 14).

### **Professional Identity**

"...the merging of one's values, theoretical beliefs, and skills. It involves shedding values, beliefs, and skills that no longer fit and adding others" (Skovholt & Trotter-Mathison, 2014, p. 40).

### **Secondary Trauma/Traumatization**

"... the suffering that occurs as a result of a therapist's close relationships with people who have experienced trauma" (Rothschild, 2006, p. 14).

### **Secondary Traumatic Stress**

Often considered a component of compassion fatigue, secondary traumatic stress is defined as, "...secondary exposure to people who have experienced extremely or traumatically stressful

events. The negative effects of STS may include fear, sleep difficulties, intrusive images, or avoiding reminders of the person's traumatic experiences" (Stamm, 2010, p. 13).

### **Self-Care**

"The processes of self-awareness and self-regulation and the balancing of connections among self (involving the psychological, physical and spiritual, as well as the professional), others (including personal and professional relationships), and the larger community (encompassing civic and professional involvement)" (Baker, 2003, p. 13-14).

### **Therapist Distress**

Therapist distress is a broad term for when a therapist's personal well-being is disrupted by stressors from their personal and professional roles. Examples of stressors include marital/relationship difficulties, an unsupportive work environment, fear of client suicide or homicide, financial difficulties, etc. (Baker, 2003).

### **Trauma**

"Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions." (APA, n.d.b).

### **Somatic Countertransference**

"... countertransference on a body level: body sensations or feelings that are provoked within the therapeutic encounter... may or may not have connection to something in therapist's current or earlier life" (Rothschild, 2006, p. 166).

## **Vicarious Traumatization**

“... vicarious traumatization is defined as the traumatizing effect of work with traumatized patients on the clinician’s ‘mind’ and ‘body.’ This effect endures beyond particular sessions or work with particular patients. It may become part of the clinician’s daily life” (Forester, 2007, p. 124).

## Appendix B

### Symptoms and Factors Related to Possible Risks of Being a Therapist

Table B1

*Symptoms and Factors Related to Possible Risks of Being a Therapist*

	Symptoms	Factors
<b>Burnout</b>	Physical and emotional fatigue Stress Hopelessness Emotional exhaustion Cynicism Emotional drain Frustration Helplessness Disengagement Depletion Irritability Impatience/avoidance of relationships Overextending self at work Sacrificing self-care Anger/contempt towards clients Difficulties efficiently completing work Depersonalization Despair Disillusionment Boredom Lack of professional satisfaction Symptoms of depression (without meeting criteria for <i>Diagnostic and Statistical Manual 5</i> ) Impaired concentration Substance abuse Illness Absences from work Loss of compassion	<i>Environmental/Organizational Factors:</i> Professional isolation Inadequate supervision Lack of control Interpersonal tensions Unmanageable workload Incongruence between therapist and job High turnover rates amongst staff Lack of therapeutic success Ambiguous successes Requirements to maintain current licensure and certification standards Client's need for specialized care Insufficient rewards <i>Intrapsychic Factors:</i> Self-sacrificing Unmet personal/conflicting needs Tendency to create unrealistic expectations Feelings of incompetence or inadequacy  <i>Developmental Factors:</i> Young Inexperienced
<b>Compassion Fatigue</b>	Distress in the workplace Contributing to toxic work environments with criticism and negative remarks Irritation within relationships Guilt when meeting own needs Lack of boundaries Predisposition to clinical errors Sense of helplessness and confusion Feelings of isolation Intrusive symptoms (e.g. intrusive images) Avoidance symptoms (e.g. depersonalization) Arousal symptoms (e.g. hypervigilance)	Use of empathy Experiences of personal trauma Unresolved trauma similar to client's trauma history Working with children with experiences of trauma Inability to maintain professional boundaries Untreated anxiety/depression of therapist Ineffective coping styles Lack of leadership and support Current personal life events (e.g. divorce, bereavement) Unrealistic expectations Unmanageable workloads Working with patients at end of life
<b>Countertransference</b>	Overidentifying with client  Feelings interfering with therapeutic relationship/process (e.g. shame, fear, sexual attraction, dread)  Inappropriate images and thoughts about client	
<b>Somatic Countertransference</b>	Sensations in therapist's body as reaction to client (e.g. nausea, physical aches/pains, numbness)  Unbidden images, fantasies, or sounds  Continuum of sensations to sensory experiences (e.g. dissociation)	
<b>Therapist Distress</b>	Disruption in appetite/eating Difficulty sleeping Loss of energy Decreased exercise Physical pain(s) Irritability Boredom Feelings of hopelessness and worthlessness Increased substance use Anxiety Feelings of failure Low self-esteem Fear of taking time off Withdrawal in relationships Feeling easily overwhelmed	Fear of client suicide/homicide Feelings of countertransference Marital/relationship difficulties Life transitions for therapist Anxiety Concerns for career Death of a client/loved one Unsupportive work environment Prolonged difficult situations School-related stressors (e.g. exams) Disruption of social support Financial pressures Self-doubt First time experiences with clients Inadequate supervision Client distress Self-awareness of own issues
<b>Vicarious Traumatization</b>	Depression Feelings of hopelessness and despair Startle-responses Freezing-responses Reactivity to specific triggers Hypervigilance Nightmares Shortness of breath Heart palpitations Disrupted sleep patterns Numbness Physical pains/sensitivities	

(Baker, 2003; Bride et al., 2007; Cummins, 2007; Cushway, 1997; Diaconescu, 2015; Figley, 2002; Forester, 2007; Harris, 2009; Hughes, 2014; Jacobson et al., 2013; Lengerich, 2001; Maslach, 2003; McCann & Pearlman, 1990; Melius, 2013; Munnell Trif, 2010; Osborn, 2004; Richards et al., 2014; Rothschild, 2006; Stamm, 2010)

## Appendix C

### Models of Wellness

# THE INDIVISIBLE SELF: *An Evidence-Based Model Of Wellness*

## CONTEXTS:

### **Local (safety)**

Family  
Neighborhood  
Community

### **Institutional (policies & laws)**

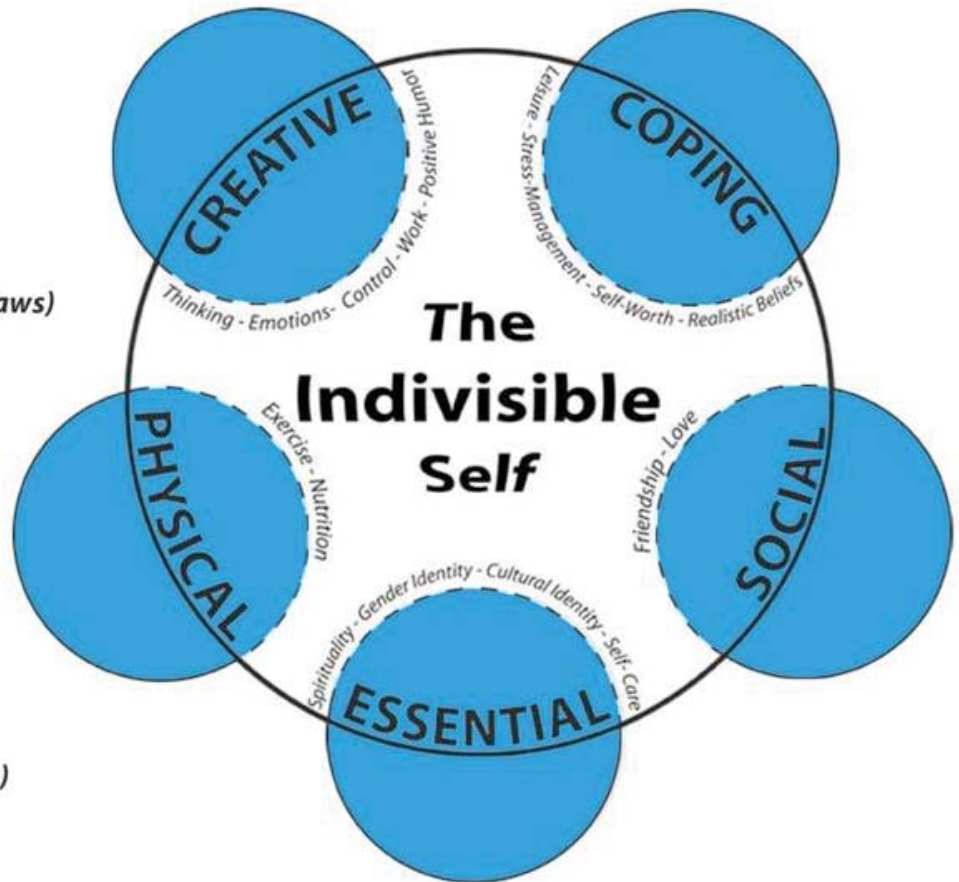
Education  
Religion  
Government  
Business/Industry

### **Global (world events)**

Politics  
Culture  
Global Events  
Environment  
Media

### **Chronometrical (lifespan)**

Perpetual  
Positive  
Purposeful



© T.J. Sweeney & J.E. Myers, 2003.

(Myers & Sweeney, 2005)



(Hierarchy of needs (1990's eight-stage model based on Maslow), n.d.)

## Appendix D

### Online Survey: Self-Care Practices as a DMT Intern

**Self-Care Definition:** “The processes of self-awareness and self-regulation and the balancing of connections among self (involving the psychological, physical and spiritual, as well as the professional), others (including personal and professional relationships), and the larger community (encompassing civic and professional involvement)” (Baker, 2003, p. 14).

1. What was your age during your practicum and/or internship experiences at Columbia College Chicago?
  - a. 20-29
  - b. 30-39
  - c. 40-49
  - d. 50-59
2. Was your first experience as a therapy intern through the Dance/Movement Therapy & Counseling program at Columbia College Chicago?
  - a. Yes
  - b. No
3. Did you have a career established prior to beginning the DMTC program at Columbia College Chicago?
  - a. Yes (please provide a description below)
  - b. No
4. Had you previously worked in within the mental health field?
  - a. Yes (please describe below)
  - b. No
5. What population(s) did you work with as a DMT intern at Columbia College Chicago?

**Vicarious Traumatization Definition:** “... vicarious traumatization is defined as the traumatizing effect of work with traumatized patients on the clinician’s ‘mind’ and ‘body.’ This effect endures beyond particular sessions or work with particular patients. It may become part of the clinician’s daily life” (Forester, 2007, p. 124).

Examples of symptoms include feelings of hopelessness and despair, overactive startle-responses, freezing-responses, reactivity to specific triggers, hypervigilance, nightmares, shortness of breath, heart palpitations, disrupted sleep patterns, numbness, physical pains and sensitivities (Diaconescu, 2015; Forester, 2007; Melius, 2013; Munnell Trif, 2010).

6. Did you ever experience any symptoms of vicarious traumatization while an intern at Columbia College Chicago? (Please refer to the above definition.)
  - a. Yes
  - b. No
  - c. Unsure/Can’t Remember
7. How frequently did you experience symptoms of vicarious traumatization while an intern?
  - a. Daily



- b. Weekly
  - c. Monthly
  - d. Other (please specify)
8. Did any self-care activities help you cope with symptoms of vicarious traumatization?
- a. Yes
  - b. No
9. What specific self-care activities did you use to cope with vicarious traumatization?
10. Were there specific self-care activities you chose to exclude?
- a. Yes
  - b. No
11. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with vicarious traumatization?
- a. 1 – Not at all effective
  - b. 2
  - c. 3
  - d. 4
  - e. 5 – Very effective

**Therapist Distress Definition:** Therapist distress is a broad term for when a therapist's personal well-being is disrupted by stressors from their personal and professional roles. Examples of stressors include marital/relationship difficulties, an unsupportive work environment, fear of client suicide or homicide, financial difficulties, etc.

Symptoms of distress include a disruption in appetite or eating, difficulty sleeping, loss of energy, decreased exercise, physical pain(s), irritability, boredom, feelings of hopelessness and worthlessness, increased substance use, anxiety, feelings of failure, lowered self-esteem, fear of taking time off, withdrawal in relationships, and feeling easily overwhelmed (Baker, 2003; Hughes, 2014; Lengerich, 2001).

12. Did you ever experience any symptoms of therapist distress while an intern at Columbia College Chicago? (Please refer to the above description.)
- a. Yes
  - b. No
  - c. Unsure/Can't Remember
13. How frequently did you experience symptoms of therapist distress while an intern?
- a. Daily
  - b. Weekly
  - c. Monthly
  - d. Other (please specify)
14. Did any self-care activities help you cope with symptoms of therapist distress?
- a. Yes
  - b. No
15. What specific self-care activities did you use to cope with therapist distress?
16. Were there specific self-care activities you chose to exclude?
- a. Yes
  - b. No

17. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with therapist distress?
- 1 – Not at all effective
  - 2
  - 3
  - 4
  - 5 – Very effective

**Countertransference Definition:** "Countertransference is from psychodynamic therapy and an emotional reaction to a client by the therapist—irrespective of empathy, the trauma, or suffering. It is defined as the process of seeing oneself in the client, of over identifying with the client, or of meeting needs through the client... countertransference is chronic attachment associated with family of origin relationships and has much less to do with empathy toward the client that causes trauma" (Figley, 2002, p. 1435-1436).

Examples of countertransference experiences include feelings that interrupt the therapeutic process, such as resentment, shame, fear, anxiety, inadequacy, anger, pain, confusion, sexual attraction, frustration, self-doubt, guilt, denial, avoidance, rage, and dread (Baker, 2003; McCann & Pearlman, 1990).

18. Did you ever experience any symptoms of countertransference while an intern at Columbia College Chicago? (Please refer to the above description.)
- Yes
  - No
  - Unsure/Can't Remember
19. How frequently did you experience symptoms of countertransference while an intern?
- Daily
  - Weekly
  - Monthly
  - Other (please specify)
20. Did any self-care activities help you cope with symptoms of countertransference?
- Yes
  - No
21. What specific self-care activities did you use to cope with countertransference?
22. Were there specific self-care activities you chose to exclude?
- Yes
  - No
23. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with countertransference?
- 1 – Not at all effective
  - 2
  - 3
  - 4
  - 5 – Very effective

**Somatic Countertransference Definition:** Somatic countertransference is "countertransference on a body level: Body sensations or feelings that are provoked within the therapeutic encounter... may or may not have connection to something in therapist's current or earlier life" (Rothschild, 2006, p. 166).

Symptoms of somatic countertransference "can be thought of as occurring on a continuum, from pure sensation to sensory experiences that are affectively or cognitively involved" (Forester, 2007, p. 129). Examples of symptoms may include nausea, physical aches or pains, numbness in parts of the body, and muscle tension.

24. Did you ever experience any symptoms of somatic countertransference while an intern at Columbia College Chicago? (Please refer to the above description.)
  - a. Yes
  - b. No
  - c. Unsure/Can't Remember
25. How frequently did you experience symptoms of somatic countertransference while an intern?
  - a. Daily
  - b. Weekly
  - c. Monthly
  - d. Other (please specify)
26. Did any self-care activities help you cope with symptoms of somatic countertransference?
  - a. Yes
  - b. No
27. What specific self-care activities did you use to cope with somatic countertransference?
28. Were there specific self-care activities you chose to exclude?
  - a. Yes
  - b. No
29. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with somatic countertransference?
  - a. 1 – Not at all effective
  - b. 2
  - c. 3
  - d. 4
  - e. 5 – Very effective

**Burnout Definition:** "Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems" (Maslach, 2003, p. 2).

Possible symptoms may include physical/emotional fatigue, hopelessness, cynicism, impatience or avoidance of relationships, sacrificing self-care, anger or contempt towards clients, depersonalization, despair, disillusionment, lack of professional satisfaction, impaired concentration, substance abuse, illness, and/or increasing amounts of absences from work

(Baker, 2003; Diaconescu, 2015; McCann & Pearlman, 1990; Melius, 2013; Richards, Sheen, & Mazzer, 2014; Stamm, 2010).

30. Did you ever experience any symptoms of burnout while an intern at Columbia College Chicago? (Please refer to the above description.)
  - a. Yes
  - b. No
  - c. Unsure/Can't Remember
31. How frequently did you experience symptoms of burnout while an intern?
  - a. Daily
  - b. Weekly
  - c. Monthly
  - d. Other (please specify)
32. Did any self-care activities help you cope with symptoms of burnout?
  - a. Yes
  - b. No
33. What specific self-care activities did you use to cope with burnout?
34. Were there specific self-care activities you chose to exclude?
  - a. Yes
  - b. No
35. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with burnout?
  - a. 1 – Not at all effective
  - b. 2
  - c. 3
  - d. 4
  - e. 5 – Very effective

**Compassion Fatigue Definition:** “The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other fatigue, reduces our capacity or interest in bearing the suffering of others” (Figley, 2002, p. 1434).

Symptoms of compassion fatigue tend to have a **quicker onset than burnout** and may include feelings of distress, feelings of guilt when advocating for needs, lack of boundaries with client(s), a sense of helplessness and confusion, and feelings of isolation (Diaconescu, 2015; Figley, 2002). However, compassion fatigue will also include intrusive symptoms, avoidance symptoms, and arousal symptoms, such as intrusive thoughts or images and avoidant behaviors (Figley, 2002; Jacobson et al., 2013; Melius, 2013).

36. Did you ever experience any symptoms of compassion fatigue while an intern at Columbia College Chicago? (Please refer to the above description.)
  - a. Yes
  - b. No
  - c. Unsure/Can't Remember
37. How frequently did you experience symptoms of compassion fatigue while an intern?

- a. Daily
  - b. Weekly
  - c. Monthly
  - d. Other (please specify)
38. Did any self-care activities help you cope with symptoms of compassion fatigue?
- a. Yes
  - b. No
39. What specific self-care activities did you use to cope with compassion fatigue?
40. Were there specific self-care activities you chose to exclude?
- a. Yes
  - b. No
41. On a scale of 1 to 5, how effective would you rate your self-care activities to cope with compassion fatigue?
- a. 1 – Not at all effective
  - b. 2
  - c. 3
  - d. 4
  - e. 5 – Very effective
42. Did you learn of any resources that were helpful in developing a self-care practice as an intern?
43. Where did you learn about these self-care resources? (If response to Question 42 was no, you can respond with N/A.)

For the questions on this page, I will be asking about specific categories of self-care as defined below:

- **Physical** - Physical self-care revolves around care of the body, such as caring for basic needs (air, food, drink, shelter, warmth, sex, and sleep), physical exercise, and nutrition.
- **Emotional** - Tending to our emotional self involves tuning in to our emotional processes, noticing how self-care choices are influencing our emotions, and expressing our emotions in healthy/helpful ways.
- **Psychological** - Tending to our psychological self involves caring for our mental and cognitive processes and providing psychological nurturance.
- **Spiritual** - The spiritual self is what helps people connect to a higher purpose or finding meaning in life, whether through a specific spiritual/religious practice or not.
- **Relational** - The relational self involves the therapist's relationship to self and how they are connected to others.
- **Professional** - Professional self-care practices are focused on activities that can be practiced in the context of an internship site or other professional contexts.

44. When considering the different categories of self-care (as defined above), were there categories you prioritized in your personal practice?
- a. Yes (If you answered yes, please list which categories of self-care you prioritized:)
  - b. No
45. Were there categories of self-care you found difficult to include in your practice?
- a. Yes (If yes, why did you find it difficult to include certain categories?)

b. No

46. Where did you learn your self-care techniques (e.g. websites, books, videos, specific people)?
47. How important do you consider developing a self-care practice while in graduate school?
48. What type(s) of self-care resource(s) would you have found most helpful when you were a student intern? (Examples: booklet, website, video, etc.)

## Appendix E

### Content-Analytic Summary Table

Possible Risks of Being a Therapist						
Categories of Self-Care	Burnout (166)	Compassion Fatigue (93)	Countertransference (111)	Somatic Countertransference (148)	Therapist Distress (223)	Vicarious Traumatization (181)
Physical (234)	Basic needs (16): hygiene, resting, sleeping	Basic needs (4): resting, sleeping	Basic needs (1): sleeping	Basic needs (7): hygiene, hydrating, resting, sleeping	Basic needs (11): hygiene, sleeping	Basic needs (5): hydrating, hygiene, naps/sleep
	Body-based practices (3): bodywork, massage, spa		Body-based practices (1): massage	Body-based practices (8): active recuperation, aromatherapy, massage, sensory stimulation, spa	Body-based practices (13): aromatherapy, body-based wellness practices, manicure, massage, minimize physiological stress, spa	Body-based practices (13): aromatherapy, massage, Rolfing, spa
	Nutrition/substance use (9): alcohol, desserts, smoking, tea	Nutrition/substance use (6): alcohol, healthy eating, smoking		Nutrition/substance use (4): alcohol, healthy eating, smoking	Nutrition/substance use (10): alcohol, desserts, eating healthy, smoking, tea, vitamins	Nutrition/substance use (6): alcohol, healthy eating, smoking, tea
Emotional (182)	Physical activity (18): biking, exercising, movement, running, walking, Zumba	Physical activity (8): exercising, movement, swimming, walking	Physical activity (11): exercising, movement, walking, running	Physical activity (24): biking, gym, exercise, kickboxing, movement, running, stretching, walking	Physical activity (28): biking, exercise, gym, movement, running, swimming, walking	Physical activity (28): biking, exercising, movement, running, swimming, walking
	Creative activities (14): art-making, choreographing, dancing, drawing, music, writing	Creative activities (10): art-making, dancing, music, poetry	Creative activities (6): art-making, dancing, drawing	Creative activities (12): choreographing, dancing, writing	Creative activities (28): art-making, dancing, drawing, music, painting, poetry, writing	Creative activities (22): art-making, choreographing, dancing, drawing, music
	Expressing emotions (5): journaling	Expressing emotions (3): journaling	Expressing emotions (9): journaling	Expressing emotions (2): journaling	Expressing emotions (6): journaling, providing emotional space for self	Expressing emotions (5): journaling
Professional (179)	Leisure activities (18): baking, cooking, humor, internet, movies, play, reading, TV	Leisure activities (3): humor, reading, TV		Leisure activities (2): TV	Leisure activities (22): baking, cooking, humor, internet, movie, reading, sing, traveling, TV	Leisure activities (15): cooking, internet, reading, shopping, singing, traveling, TV
	Body/mind practices (3): breathwork, grounding, rituals	Body/mind practices (5): breathwork, grounding, spatial boundary setting	Body/mind practices (10): Bartenieff Fundamentals, cleansing ritual, breathwork, grounding	Body/mind practices (25): body scanning, breathwork, energy clearing ritual, grounding, tracking sensations/images/emotions/thoughts, washing hands	Body/mind practices (10): breathwork, energy clearing ritual, grounding, vertical roll-downs	Body/mind practices (12): Bartenieff Fundamentals, cleansing rituals, breathwork, grounding, stillness, tracking sensations
	Environmental (2): changing environments, unplugging from technology	Environmental (1): changing environments		Environmental (2): changing clothes, changing environments		
Relational (127)	Expectations (2): adjusting responsibilities	Expectations (2): adjusting responsibilities			Expectations (1): adjusting responsibilities	
	Interpersonal (10): setting boundaries, supervision	Interpersonal (14): setting boundaries, supervision	Interpersonal (25): supervision	Other professional activities (1): clinical documentation	Interpersonal (8): supervision	Interpersonal (7): supervision
	Time management (9): time off/vacations, scheduling time to eat, taking breaks, adjusting schedule	Time management (5): time off, taking breaks, arriving early	Time management (1): taking breaks	Time management (1): taking breaks	Time management (3): scheduling time to eat, taking breaks	Time management (5): taking breaks, taking time off
Spiritual (106)	Relation to self (1)			Relation to self (1): self-touch	Relation to self (1): time alone	Relation to self (2): self-compassion, self-touch
	Sex (1)	Sex (1)				Sex (2)
	Social support (29): cohort/peers, colleagues, family, friends, instructors	Social support (10): cohort/peers, colleagues, family, friends	Social support (14): cohort/peers, colleagues, friends, instructors	Social support (8): cohort/peers, colleagues, friends, instructors, significant others	Social support (41): cohort/peers, colleagues, family, friends, instructors, pets, significant others	Social support (16): cohort/peers, family, friends, pets
Psychological (94)	Seeking spiritual support (1)		Seeking spiritual support (1)	Seeking spiritual support (1)		
	Spiritual activities (14): meditation, nature, prayer, yoga	Spiritual activities (10): meditation, nature, religious services, yoga	Spiritual activities (9): meditation, nature, yoga	Spiritual activities (20): meditation, nature, yoga	Spiritual activities (22): affirmations, meditation, nature, prayer, religious services, yoga	Spiritual activities (28): meditation, nature, prayer, religious services, yoga
		Body/mind practices (3): mindfulness, relaxation exercises	Body/mind practices (3): mindfulness	Body/mind practices (4): mindfulness, relaxation exercises	Body/mind practices (2): mindfulness	
		Furthering education (1)	Further education (1): self-help books		Furthering education (2): continuing school, watching/reading news	
					Simplifying (2): cleaning	Simplifying (1): cleaning
	Thought processes (4): compartmentalizing, optimism, slowing down		Thought processes (5): positive self-talk, processing, self-reflection	Thought processes (1): processing	Thought processes (2): positive self-talk, slowing down	Thought processes (2): positive self-talk, self-awareness
	Therapy (7)	Therapy (7): authentic movement	Therapy (14): dance/movement therapy	Therapy (10): authentic movement, dance/movement therapy	Therapy (13): dance/movement therapy	Therapy (10): authentic movement